Texas Medicaid Managed Care STAR Child, STAR Adult, and STAR+PLUS Adult Behavioral Health Survey Report

Contract Year 2015

Recall Period STAR Child and STAR Adult: July 2014 through September 2015

Recall Period STAR+PLUS Adult: August 2014 through September 2015

The Institute for Child Health Policy

University of Florida

The External Quality Review Organization

for Texas Medicaid Managed Care and CHIP

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1. Executive Summary

Introduction

Behavioral health disorders including mental health and substance use disorders are prevalent and are associated with a high rate of health service utilization.[1] Across the United States, approximately 11 percent of adult Medicaid members have a mental health disorder[2] and 12 percent have a substance use disorder.[3] In Texas Medicaid and CHIP managed care, members receive behavioral health services through a managed care organization (MCO) integrated benefits package or through a sub-contracted behavioral health organization (BHO), depending on their MCO and service area.

The Institute for Child Health Policy (ICHP), the external quality review organization (EQRO) for the Texas Health and Human Services Commission (HHSC), contracted with HHSC to evaluate members' experiences and satisfaction with their behavioral health services while enrolled in either the STAR or STAR+PLUS program. The EQRO conducted three member behavioral health surveys between June 2015 and September 2015, which served two main purposes:

(1) Describe child and adult STAR members' and adult STAR+PLUS members' demographic and health characteristics (including overall health, mental health, and body mass index).
(2) Examine and compare child and adult STAR members' and adult STAR+PLUS Medicaid-only members' experiences and satisfaction with behavioral health services received through their MCO or BHO across multiple domains.

Methods

The EQRO conducted member and caregiver surveys between June 2015 and September 2015 with members or caregivers of children who had a record of one or more mental health and/or substance use disorder diagnoses and procedures during the enrollment period of April 2014 to March 2015.

The EQRO selected members from stratified random samples. The STAR child behavioral health survey was stratified among four age and developmental quotas. The STAR adult behavioral health survey was stratified according to three delivery models. The STAR+PLUS adult behavioral health survey was stratified among seven quotas, based on program/MCO membership and eligibility for Medicare.

All behavioral health surveys included the following measures:

- The Experience of Care and Health Outcomes (ECHO®) Survey 3.0., which assesses members' experiences and satisfaction with behavioral health services.
- Items developed by the EQRO pertaining to member demographic and household characteristics and self-reported height and weight to calculate body mass index (BMI).

Results

Demographic Characteristics Across Programs

- The majority of respondents were female: STAR child caregivers (91.4 percent), STAR adult (86.7 percent), STAR+PLUS adult (63.8 percent).
- The majority of respondents spoke English at home: STAR child caregivers (84.3 percent), STAR adult (89.7 percent), STAR+PLUS adult (90.1 percent).
- At least one-third of respondents were Hispanic: STAR child caregivers (52.6 percent), STAR adult (43.5 percent), STAR+PLUS adult (32.7 percent).
- The average age of respondents was 40 years for STAR child caregivers, 34 years for STAR adult members, and 50 years for STAR+PLUS adult members.

Main Findings and Recommendations

Main findings and recommendations for STAR child members are presented in **Table 1**, for STAR adult members in **Table 2**, and for STAR+PLUS adult members in **Table 3**.

Table 1. STAR Child Members - Main Findings and Recommendations (N = 1,029)

Main Findings	Recommendations for STAR Child MCOs
At least three-quarters of caregivers provided high ratings of their child's counseling or treatment as well as their child's health plan (mean rating of 8 or higher on a 0-10 scale).	Assess the experiences of the one-quarter of caregivers who reported lower ratings of counseling or treatment and the health plan to improve overall quality and provision of behavioral health care, which is also a goal of the DSRIP incentives initiative.[4]
More than one-third of children were considered obese.	Continue comprehensive efforts that prevent, identify, and address childhood obesity (e.g., focus on exercise, diet, and environment),[5] because childhood obesity is linked to quality of life and physical and mental well-being.[6]
Half of caregivers thought their child had improved "a lot" and was "much better" across multiple domains compared to one year ago.	Identify the needs of the other half of child members whose caregivers did not report "a lot" of improvement or that the child was "much better" than one year ago. Focus studies could be used to discover barriers to greater improvement.
Thirty percent of caregivers reported delays in counseling or treatment for their child while awaiting approval from their health plan as a "big problem." Forty-three percent of caregivers thought their child still needed counseling or treatment, which is among those whose benefits were used up (23 percent had used up their benefits).	Ensure adequate and timely access to behavioral health counseling or treatment. This is particularly important for child members because they experience rapid growth and associated physical and psychological changes.

Table 2. STAR Adult Members - Main Findings and Recommendations (N = 642)

Main Findings	Recommendations for STAR Adult MCOs
At least three-quarters of STAR adult members received information from their clinician about managing their mental health condition and felt they could refuse medication or treatment for their mental health condition.	Continue to improve communications between STAR adult members and clinicians, especially for those members who did not receive information on how to manage their mental health condition. AHRQ provides tips for patients and clinicians on how to improve their communication[7] and also for patients on how to be more involved in (e.g., questions to ask) and make better decisions about the care they receive.[8]
Half of STAR adult members were obese. Less than one in five members reported "excellent" ratings on their overall health, mental health, and recovery from substance use disorders.	Provide health intervention programs that address the specific needs of STAR adult members with behavioral health disorders because they have an increased risk of being overweight and obese.[9] Weight gain, for example, is associated with certain medications (e.g., antipsychotics, antidepressants)[10] and subsequent lack of medication compliance,[11] increasing the risk of worsening mental well-being.
One-third of members perceived their improvement as "much better" across multiple domains compared to one year ago.	Conduct focus studies with STAR adult members who did not greatly improve over the past 12 months to identify barriers (e.g., personal, health, MCO) they face to better health outcomes.
Four in ten members reported they could get treatment quickly (urgent and routine counseling or treatment). One-quarter of members used up their benefits for counseling or treatment; of those, 60 percent thought they still needed treatment. Slightly less than half of members thought that behavioral health counseling or treatment helped them "a lot."	Increase providers' implementation of behavioral health promotion programs in STAR to improve members' access to counseling or treatment (e.g., after benefits are used up, getting treatment quickly). Results from prior administrative interviews showed that only 53 percent of MCOs included substance abuse management, 47 percent obesity prevention, 68 percent weight management, and 74 percent physical activity,[12] all of which are important to members with behavioral health disorders.

Table 3. STAR+PLUS Adult Members - Main Findings and Recommendations (N = 1,483)

Main Findings	Recommendations for STAR+PLUS Adult MCOs
At least three-quarters of STAR+PLUS adult members received counseling or treatment for mental health disorders, information from their clinician about managing their mental health condition, and took prescription medication as part of their mental health treatment.	Continue to encourage STAR+PLUS members to be active participants in their behavioral health care because patient engagement is related to better health outcomes.[13] Also, identify those members who did not receive counseling or treatment and information on how to manage their disorders. Conduct focus studies to examine the barriers they encounter to better behavioral health care and outcomes.
Half of STAR+PLUS adult members were obese. Less than one in six members rated their overall health, mental health, and recovery from substance use disorders as “excellent." Half of members thought that counseling or treatment helped them “a lot” and was “very helpful” for their quality of life. One-quarter of members said they were “much better” across multiple domains than one year ago.	Tailor health interventions to the unique needs of individuals with behavioral health disorders (e.g., weight management, substance use disorders, relapse prevention, psychiatric symptoms)[14] to improve well-being and quality of life. Additionally, ensure that health interventions are reaching STAR+PLUS members. Results from a prior administrative interview survey showed that the vast majority of MCOs included educational materials and referrals to community resources. However, MCOs noted concerns about a large number of incorrect member addresses and returned mailings. Studies are needed that examine the extent of this issue to ensure greater outreach.[15]
One-half of members were aware of available service coordination; among those who were aware, only one-half used the service.	Increase efforts to raise members’ awareness of STAR+PLUS service coordination availability, which provides a range of services to address their complex needs.[16]
Four in ten members received behavioral health counseling or treatment in the emergency department or crisis center.	Conduct studies that assess reasons for behavioral health-related emergency department or crisis center utilization.

2. Introduction

Behavioral health disorders encompass both mental health and substance use disorders that can be treated with counseling, pharmacotherapy, or both. Treatment is specific to the needs of members with behavioral health disorders. The percentage of Medicaid members with behavioral health disorders is high, with more than one in 10 (11 percent) Medicaid members having a mental health disorder[17] and 12 percent having a substance use disorder.[18] In addition, utilization of health services is higher and more costly among Medicaid members with behavioral health disorders than among members without behavioral health disorders.[19] For example, Medicaid members with mental health disorders account for close to 30 percent of all Medicaid expenditures.[20] Additionally, almost 12 million emergency department visits are made by individuals with a behavioral health disorder and one-quarter of hospital admissions are linked to individuals with behavioral health disorders.[21]

Early intervention and prevention is the key to improving Medicaid members' behavioral health. As Medicaid is the single largest payer for mental health services and is continually expanding the reimbursement of substance use disorder services, low-income adults and children living in low-income families have access to comprehensive behavioral health services including counseling, case management, and prescription benefits.[22,23] In fact, Medicaid comprises 27 percent of all mental health services expenditures.[24] In Texas Medicaid managed care and CHIP, members can receive behavioral health services through their MCOs' integrated benefits package or through a sub-contracted BHO, depending on their MCO and the service area in which they live. STAR and STAR+PLUS members living in the Dallas area receive behavioral health care through the NorthSTAR program, which contracts with the ValueOptions BHO.

In 2009, the Texas Legislative Budget Board (LBB) staff recommended that the state implement surveys to assess member satisfaction and experiences with the behavioral health services they receive through their Medicaid MCO or BHO.[25] Member satisfaction surveys can identify aspects of behavioral health services and treatment that are important to patients and help programs determine areas of behavioral health care that need improvement.

The Institute for Child Health Policy at the University of Florida, which contracts with the Texas Health and Human Services Commission (HHSC) as the EQRO for Texas Medicaid and CHIP, evaluated members' and caregivers' experiences and satisfaction with their or their child's behavioral health care services while enrolled in either the STAR or STAR+PLUS program. Additionally, members had to have received ambulatory or inpatient care services for one or more specified behavioral health conditions with no more than one 30-day gap during the sampling enrollment period. Members' ratings of satisfaction with health care are an indicator of quality of care, which has been linked with positive health-related behaviors, such as compliance with treatment.[26,27] The EQRO conducted three member surveys between June 2015 and September 2015, including ECHO® surveys with parents and caregivers of children enrolled in STAR, adult members enrolled in STAR, and adult members enrolled in STAR+PLUS. All surveys had a 12-month recall period, in which members were asked to recall

their experiences with the services they received within the last 12 months from the date of the call.

The member behavioral health surveys served two purposes:

- Describe child and adult members' demographic and household characteristics, as well as overall health including obesity and mental health.
- Examine and compare experiences and satisfaction with received behavioral health services across multiple domains through their MCO or BHO, including:
  (1) utilization of behavioral health counseling and treatment;
  (2) access to and timeliness of behavioral health care;
  (3) MCO or BHO behavioral health treatment benefits, information, and assistance;
  (4) experiences with clinicians and health plans; and
  (5) Perceived outcomes of behavioral health counseling and treatment.

3. Methods

This section describes the methodology used to conduct the member behavioral health surveys and to generate this report.

Sample Selection Procedures

STAR Child Behavioral Health Survey

Children in STAR were selected from a stratified random sample of children continuously enrolled in STAR between April 2014 and March 2015 (with one allowable one-month gap in enrollment during the 12-month period). The STAR child behavioral health survey included only children younger than 18 years of age with a record of having received ambulatory or inpatient behavioral health care services during the evaluation period, as determined from qualifying procedure codes for three 2015 HEDIS® indicators—Mental Health Utilization (MPT); Identification of Alcohol and Other Drug Services (IAD); and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (**Table 4**).

Table 4. STAR Child, STAR Adult, and STAR+PLUS Adult Behavioral Health Survey Sampling: 2015 HEDIS® Indicators with Qualifying Procedure Codes

2015 HEDIS® Measures	Indicators with Qualifying Procedure Codes
MPT	Intensive Outpatient/Partial Hospitalization
	Outpatient or Emergency Department
IAD	Ambulatory Services
	Intensive Outpatient/Partial Hospitalization
IET	Initiation of AOD Treatment at ages13-17 and 18+

The sample was stratified among four age and developmental quotas: (1) STAR children who were 12 years of age or younger, (2) STAR adolescents who were 13 to 17 years of age, (3) NorthSTAR children who were 12 years of age or younger, and (4) NorthSTAR adolescents who were 13 to 17 years of age. These criteria are based on the technical specifications for the ECHO® survey and ensure that children in the sample received behavioral health services during the enrollment period, and that families had sufficient experience with the program to respond to the survey questions.

The EQRO set a target sample of 1,200 completed telephone interviews with caregivers, representing 300 respondents for each of the quotas. A total of 1,029 caregivers of children in STAR participated in the survey (**Table 5**). Attempts were made to contact 13,257 caregivers of STAR and NorthSTAR members. Fifty-two percent of families could not be located[1]. Among those located, less than one percent indicated that they were not enrolled in STAR or NorthSTAR, and two percent refused to participate. The response rate was 48 percent, and the cooperation rate was 91 percent.

[1] Non-location rate includes call attempts that ended in busy signals, no answer, technical phone problems, fax/data line numbers, non-working numbers, disconnected numbers, government organizations, and other call attempts that resulted in the failure to confirm the number dialed belonged to the member.

Table 5. STAR Child Behavioral Health Survey Sampling

Program/Age Quotas	Target Number of Completes	Total Completed
1. STAR - Children ages 12 and younger	300	271
2. STAR - Adolescents ages 13 to 17	300	278
3. NorthSTAR - Children ages 12 and younger	300	269
4. NorthSTAR Adolescents age 13 to 17	300	211
Total	**1,200**	**1,029**

STAR Adult Behavioral Health Survey

Adult members in STAR were selected from a stratified random sample of adults continuously enrolled in STAR between April 2014 and March 2015 (with one allowable one-month gap in enrollment during the 12-month period). The STAR adult behavioral health survey included only adults ages 18 to 64 with a record of having received ambulatory or inpatient behavioral health care services during the evaluation period, as determined from qualifying procedure codes for the three 2015 HEDIS® indicators in **Table 4**.

The 2015 STAR adult behavioral health survey was stratified according to three delivery models: (1) MCO (behavioral health care provided through the member's MCO), (2) BHO (behavioral health care provided through an external BHO), and (3) NorthSTAR.[28] Three MCOs operated in the Dallas service area (SA): Amerigroup, Molina, and Parkland; members in these MCOs living in the Dallas SA were sampled only for the NorthSTAR quota. The EQRO set a target sample of 900 completed telephone interviews with members, representing 300 respondents for each of the quotas (Table 6). Attempts were made to contact 8,171 STAR and NorthSTAR members. Forty-six percent of families could not be located. Among those located, less than one percent indicated that they were not enrolled in STAR or NorthSTAR, and two percent refused to participate. The response rate was 64 percent, and the cooperation rate was 94 percent.

Table 6. STAR Adult Behavioral Health Survey Sampling

Quota	MCOs in Quota	Behavioral Services Provided through	Target Sample	Total Completed
STAR MCO model	Aetna Amerigroup (all SAs except Dallas) Community First Health Plans (CHFP) Driscoll Health Plan (DHP) El Paso First Molina (all SAs except Dallas) Texas Children's Health Plan (TCHP)	Member's MCO	300	272
STAR BHO model	Blue Cross & Blue Shield of Texas (BCBSTX) FirstCare	Magellan Healthcare	300	268
	Community Health Choice (CHC) Cook Children's Health Plan (CCHP) Sendero Seton	Beacon Health Strategies		
	Superior HealthPlan (SHP)	Cenpatico Behavioral Health Systems		
	UnitedHealthcare Community Plan (UHC)	Optum – United Behavioral Health		
NorthSTAR	Amerigroup – Dallas Molina - Dallas Parkland Community Health Plan (PCHP) - Dallas	ValueOptions	300	102
Total			**900**	**642**

STAR+PLUS Adult Behavioral Health Survey

Adult members in STAR+PLUS were selected from a stratified random sample of members continuously enrolled in STAR+PLUS between April 2014 and March 2015 (with one allowable one-month gap in enrollment during the 12-month period). The STAR+PLUS Medicaid-only adult behavioral health survey included adults between the ages of 18 and 64 with a record of having received ambulatory or inpatient behavioral health care services during the enrollment period as determined from qualifying procedure codes for the three 2015 HEDIS® indicators in **Table 4.** An important caveat here is that the Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits coverage of care in mental health and substance use disorder inpatient treatment facilities larger than 16 beds for adults between the ages of 21 and 64 years.[29] The STAR+PLUS dually eligible adult behavioral health survey included members who had a record of one or more mental health or chemical dependency diagnosis/place of service code combinations (for the facility where services were provided) during the enrollment period. It is important to point out that dually eligible members receive most outpatient behavioral health care from Medicare and intensive rehabilitation and substance use disorder services from Medicaid.

The 2015 STAR+PLUS adult behavioral health survey was stratified by quotas related to the member's program/MCO and eligibility for Medicare. Five quotas represented Medicaid-only members in each of the five STAR+PLUS MCOs: (1) Amerigroup, (2) Cigna-Healthspring (HS), (3) Molina, (4) SHP, and (5) UHC. A sixth quota represented STAR+PLUS members in the Dallas service area, who received behavioral health care through NorthSTAR. The seventh quota consisted of a statewide sample of members who are dually eligible. The EQRO set a target sample of 2,100 completed telephone interviews with STAR+PLUS adult members between July 2015 and September 2015, representing 300 respondents for each of the quotas (**Table 7**). Attempts were made to contact 20,182 STAR+PLUS and NorthSTAR members. Forty-five percent of members could not be located. Among those located, less than one percent indicated that they were not enrolled in STAR+PLUS or NorthSTAR, and three percent refused to participate. The response rate was 70 percent, and the cooperation rate was 90 percent.

Table 7. STAR+PLUS Adult Behavioral Health Survey Sampling

Quota	ECHO® Survey Version	Target Sample (N)	Total Completed
Amerigroup	MCO	300	263
Cigna-HealthSpring (HS)	MCO	300	217
Molina (except Dallas)	MCO	300	255
SHP(except Dallas)	BHO	300	267
UHC	BHO	300	245
Members who are dually eligible, statewide (except Dallas)	MCO or BHO	300	233
NorthSTAR - Dallas	BHO	300	236
Total		**2,100**	**1,716**

Survey Data Collection

The EQRO contracted with the National Opinion Research Center (NORC) at the University of Chicago to conduct the member and caregiver satisfaction surveys using computer-assisted telephone interviewing between June 2015 and September 2015. For all satisfaction surveys, the EQRO sent advance notification letters written in English and Spanish to members or their caregivers, requesting their participation in the survey. Approximately four days following each advance notification mailing, calling began on the surveys seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 20 attempts were made to reach a family before a member's phone number was removed from the calling circuit.

Survey Measures

The member behavioral health survey tools included the ECHO® Survey 3.0,[30] which is part of the Consumer Assessment of Health Providers and Systems (CAHPS®) family of surveys and has four versions determined by the members' age group (child or adult) and behavioral health service delivery model (MCO or BHO). The child version assesses parents' or caregivers' experiences and satisfaction with various aspects of their child's behavioral health services in either a MCO or BHO. The adult version assesses members' experiences and satisfaction with various aspects of their behavioral health services in either a MCO or BHO. The survey allows for calculation and reporting of behavioral health care composites, which are scores that combine results for closely related survey items. ECHO® composite scores were calculated in the following five domains: (1) G*etting Treatment Quickly,* (2) *How Well Clinicians Communicate,* (3) *Getting Treatment and Information from the Plan or Behavioral Health*

Organization, (4) *Information about Treatment Options, and* (5) *Perceived Improvement.* Researchers at ICHP scored the composites following ECHO® specifications.

Three ECHO® survey questions comprise the composite *Getting Treatment Quickly*, including questions that assess how often caregivers said their child (1) saw someone for urgent counseling or treatment as soon as they wanted, (2) got an appointment for routine counseling or treatment as soon as they wanted, and (3) got professional counseling over the telephone when needed. Six ECHO® survey questions comprise the composite *Getting Treatment and Information*. Four of these ECHO® survey questions pertain only to MCO members and two of these ECHO® survey questions pertain to both MCO and BHO members. Specifically, caregivers reported the extent to which they experienced problems in the past 12 months: (1) In finding a clinician with whom they were happy (MCO members only). (2) With delays in counseling or treatment while awaiting approval from their child's health plan (MCO and BHO members). (3) Getting counseling or treatment they thought their child needed (MCO members only). (4) In finding and understanding information (MCO members only). (5) Getting the help they needed when calling their child's health plan's customer service (MCO and BHO members). (6) With paperwork for their child's health plan (MCO members only).

Five ECHO® survey questions comprise the composite *How Well Clinicians Communicate*. This composite assesses caregivers' perceptions of how often a child's clinician or therapist (1) listened carefully, (2) explained things well, (3) showed respect for what the caregiver said, (4) spent enough time, and (5) involved the caregiver in treatment as much as they wanted. One ECHO® survey item summarized the *Information about Treatment Options* measure. This item assesses whether the clinician or therapist informed caregivers about the different kinds of counseling or treatment available for their child. Four ECHO® survey items comprise the composite *Perceived Improvement*. This composite assesses caregiver perceptions of their child's improvement compared to 12 months ago (1) in their child's ability to deal with daily problems, (2) in their child's ability to deal with social situations, (3) their child's ability to accomplish the things he or she wants to accomplish, and (4) in the overall improvement in their child's problems or symptoms.

Values for *Getting Treatment Quickly*, *How Well Clinicians Communicate,* and *Getting Treatment and Information from the Plan or Behavioral Health Organization* range from 1.00 to 3.00. Values for *Information about Treatment Options* range from 0.00 to 1.00. Values for *Perceived Improvement* range from 1.00 to 4.00. Higher values indicate greater satisfaction. For each of the five domains, a member's composite score was not calculated or considered in the analysis if the respondent answered fewer than half of the questions in the composite.

The EQRO also developed items to measure member and caregiver demographic and household characteristics, which have been used in surveys with more than 100,000 Medicaid and CHIP members in Texas and Florida. The items were adapted from questions used in the National Health Interview Survey, the Current Population Survey, and the National Survey of America's Families.[31,32,33] Members were also asked to report their or their child's height and weight in order to calculate BMI, a common population-level indicator of overweight and obesity.

This item is included in the member surveys because, unlike diabetes or high blood pressure, BMI is not reliably obtained from claims and encounter data. The extremely low administrative-only rates for the HEDIS® *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (WCC) BMI documentation supports this decision.[34] Thus, for a more complete picture of overweight and obesity in these populations, we collected member or caregiver reports.

Data Analysis

The EQRO performed descriptive statistics and formal statistical tests using SAS 9.4 (SAS, Inc., Raleigh, NC). Separate technical appendixes provide frequency tables showing descriptive results for each survey question by program. The statistics presented in this report exclude "do not know" and "refused" responses. To account for the large number of statistical comparisons of results between members who received behavioral health care through a MCO or a BHO, the EQRO assessed statistical significance using an adjusted alpha level of 0.001 to control for the increased likelihood of making a type I error (i.e., finding a significant relationship where there is none).

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not respond. Statistically significant differences were found only for STAR adult members with male members having significantly higher participation rates than female members (72.3 percent versus 62.2 percent). To further facilitate inferences from the survey results to the STAR child, STAR adult, and STAR+PLUS adult member behavioral health populations, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. The frequencies and means presented in this report and the technical appendixes that accompany this report incorporate survey weights. Additionally, this report presents findings for behavioral health surveys conducted among members in STAR (child and adult) and STAR+PLUS adults (excluding the Dallas SA). Although NorthSTAR members were also surveyed in this study, the NorthSTAR program will be phased out as of December 31, 2016 and results for this program are shown only in the technical appendixes that accompany this report.

4. Results

4.1. STAR Child Behavioral Health Survey

This section presents survey findings based on parent or caregiver reports on STAR child members regarding: (1) demographic characteristics, (2) health status (overall health, mental health, and BMI), (3) utilization of behavioral health counseling and treatment, (4) access to and timeliness of behavioral health care, (5) behavioral health treatment benefits and assistance, (6) experiences with clinicians and health plans, and (7) perceived outcomes of behavioral health counseling and treatment.

Results are presented for caregiver reports overall and by delivery model (MCO compared to BHO). Unless indicated, there were no statistically significant differences in reports between caregivers whose child received behavioral health care through a MCO compared to a BHO.

4.1.1. Demographic Characteristics (N = 1,029)

STAR child members

- Half of the children were male (55.2 percent).
- Most children were Hispanic (54.2 percent), 24.2 percent were White, non-Hispanic, 15.1 percent were Black, non-Hispanic, and 6.6 percent were “other race, non-Hispanic” which includes American Indian/Alaska Native and Asian/Pacific Islander.
- The vast majority of children spoke English at home (90.7 percent) and less than one in 10 spoke Spanish at home (8.5 percent).
- Their average age was 10.2 years (SE = 0.2; Lower Confidence Limit/CL = 9.8, Upper CL = 10.6; range 1-17 years).

Caregivers

- The vast majority of respondents were female (91.4 percent).
- Half identified as Hispanic (52.6 percent), 28.3 percent as White, non-Hispanic, 16.7 percent as Black, non-Hispanic, and 2.3 percent as “other race, non-Hispanic” which includes American Indian/Alaska Native and Asian/Pacific Islander.
- Most caregivers spoke English at home (84.3 percent) and 14.9 percent spoke Spanish at home.
- More than one-third of caregivers were married or unmarried with a partner (35.8 percent), four in ten were single (40.1 percent), and one-quarter were divorced, separated, or widowed (24.1 percent).
- Most caregivers described their households as single-parent households (61.6 percent) and 37.9 percent as two-parent households.
- Almost four in ten caregivers had a high school degree (37.5 percent), 29.4 percent had not completed high school, one quarter had some college or a 2-year degree (27.3 percent), and 5.8 percent had completed a 4-year college degree or more.
- Three-quarters of caregivers were the biological parent of the STAR child member (77.5 percent) and 18.4 percent were the grandparent.
- Caregivers were on average 40.2 years old (SE = 0.6; Lower CL = 39.1, Upper CL = 41.3; range 19-84 years).

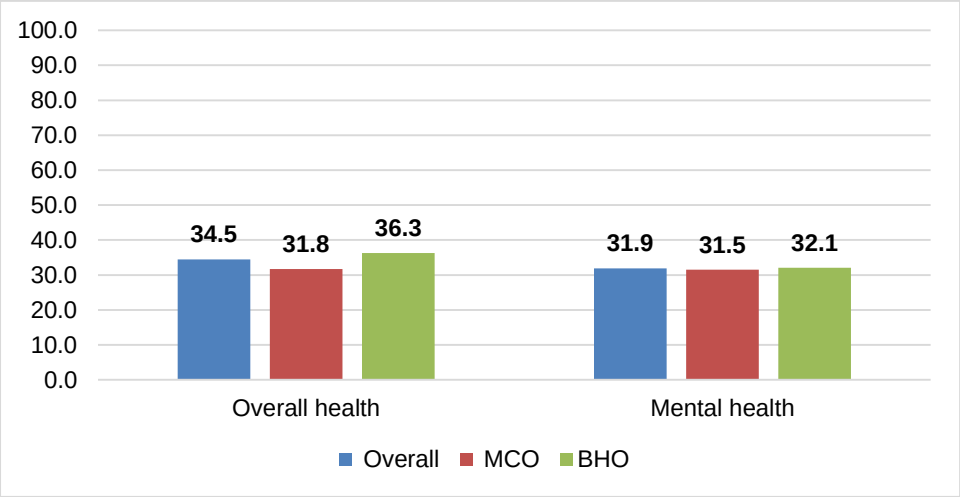
4.1.2. Health Status

Overall Health and Mental Health

One-third of caregivers rated their child’s overall health as “excellent” (34.5 percent), 29.2 percent as “very good”, and one-quarter (25.7 percent) as “good." For mental health, one-

third of caregivers rated their child's mental health as "excellent" (31.9 percent), and one-quarter as "very good" (25.9 percent) and "good" (24.1 percent).

Figure 1. Percent of Caregivers Rating Their Child in STAR in "Excellent" Overall Health and Mental Health Overall and by Delivery Model

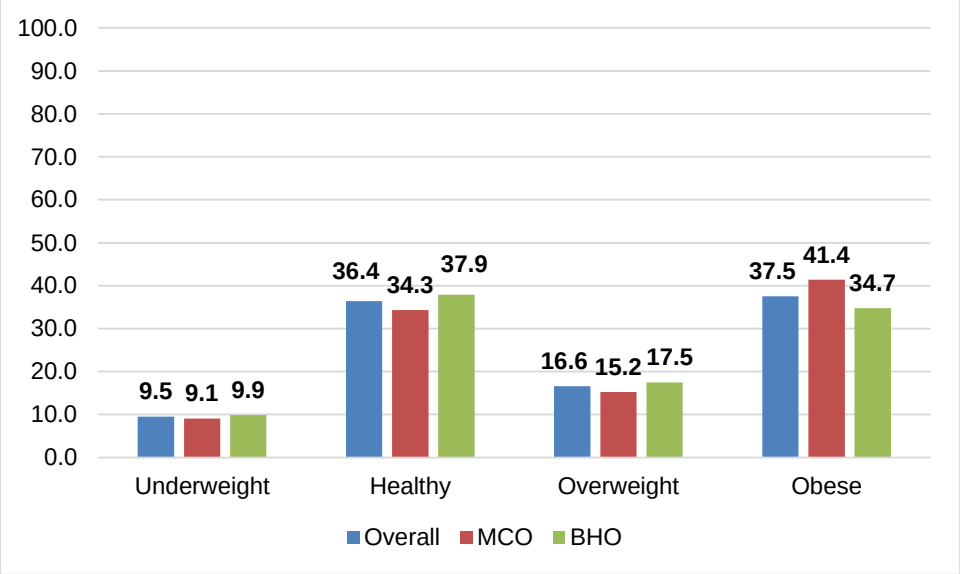


Body Mass Index

Body mass index (BMI) was calculated by dividing the child's weight in kilograms by his or her height in meters squared. BMI could be calculated only for children in the sample for whom height and weight data were complete (76.8 percent). For children, the clinical relevance of BMI values varies by sex and age. Using sex-specific, BMI-for-age growth charts from the National Center for Health Statistics (NCHS), children with valid BMI data were classified into one of four categories:[35] (1) Underweight (less than 5th percentile); (2) Healthy (5th percentile to less than 85th percentile); (3) Overweight (85th percentile to less than 95th percentile); and (4) Obese (95th percentile or greater). These standardized BMI categories for children may be used for comparison with national and state averages. Analyses of child BMI excluded children younger than two years old, for whom data are not provided on NCHS BMI-for-age growth charts. Also excluded were children whose BMI deviated considerably from child growth standards provided by the World Health Organization.[36] By these standards, any BMI value that exceeded five standard deviations below or above the median BMI was considered biologically implausible and likely the result of errors in data collection.

Figure 2 provides the BMI results. Based on height and weight data, 9.5 percent of children were underweight, 36.4 percent were at a healthy weight, 16.6 percent were overweight, and 37.5 percent of children were classified as obese.

Figure 2. STAR Child Body Mass Index Classification: Overall and by Delivery Model



4.1.3. Utilization of Behavioral Health Counseling and Treatment

This section provides results for caregivers' self-reports of their child's utilization of behavioral health services in the STAR program.

Caregivers reported whether their child had in the past 12 months:

- Gone to an emergency department or crisis center to get counseling or treatment (17.3 percent overall; 14.2 percent for MCO; 19.4 percent for BHO).
- Received counseling, treatment, or medicine at home, in an office, clinic, or other treatment program, not including emergency department or crisis center counseling or treatment (63.7 percent overall; 63.0 percent for MCO; 64.2 percent for BHO).
- Taken prescription medicine as part of his or her treatment (60.8 percent overall; 59.0 percent for MCO; 62.0 percent for BHO).

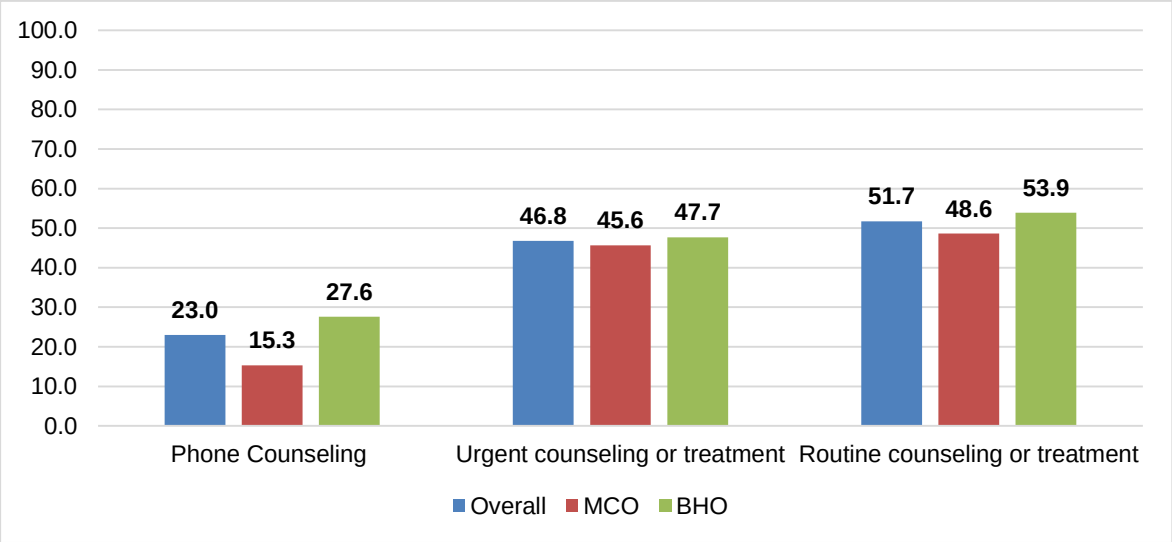
4.1.4. Access to and Timeliness of Behavioral Health Care

Getting Treatment Quickly

The mean rating for the *Getting Treatment Quickly* composite was 2.1 (SE = 0.1; Lower CL = 1.9, Upper CL = 2.2) overall, 2.0 (SE = 0.1; Lower CL = 1.8, Upper CL = 2.2) for MCO members, and 2.1 (SE = 0.1; Lower CL = 1.9, Upper CL = 2.2) for BHO members. Regarding the individual items that made up the composite, almost half of caregivers (46.8 percent) reported that they "always" got an appointment for urgent professional counseling as soon as they wanted, half (51.7 percent) "always" got a routine appointment as soon as they wanted,

and one-quarter (23 percent) “always” got professional counseling over the telephone when needed.

Figure 3. Percent of Caregivers Reporting Their Child “Always” Received Behavioral Health Treatment When Needed, by Type of Care



Office Wait

Caregivers also reported how often their child was seen within 15 minutes of his or her child’s appointment in the past 12 months. One-third (35.2 percent) of caregivers reported that their child was “always” seen within 15 minutes (35.2 percent for MCO and 35.2 percent for BHO members).

Rating of Counseling or Treatment

When caregivers were asked to rate their overall perceptions of their child’s counseling or treatment on a scale from 0 (lowest rating) to 10 (highest rating), 56.5 percent gave a rating of either “9” or “10” (56.1 percent for MCO and 56.8 percent for BHO members). The mean rating of their child’s counseling or treatment was 8.1 (SE = 0.1; Lower CL = 7.9, Upper CL = 8.3) overall, 8.2 for MCO (SE = 0.2; Lower CL = 7.9, Upper CL = 8.5), and 8.1 (SE = 0.1; Lower CL = 7.8, Upper CL = 8.4) for BHO members.

4.1.5. Behavioral Health Treatment Benefits and Assistance

This section provides results for caregivers' experiences with their child's MCO or BHO regarding available behavioral health benefits for counseling and treatment and clinician assistance.

Extended Benefits

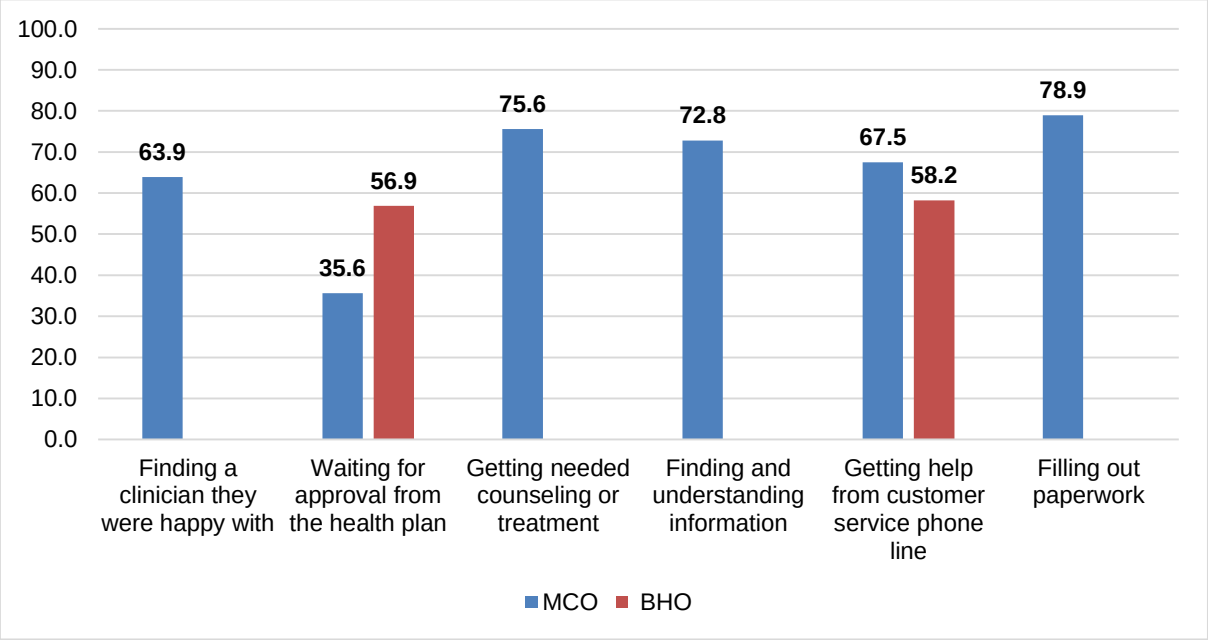
Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.[37] Caregivers were asked whether their child had used up all of his or her benefits for counseling and treatment in the last 12 months and if so, if they were still in need of counseling or treatment.

- One-quarter (23.3 percent) of caregivers reported that their child had used up all benefits for counseling or treatment in the past 12 months (24.8 percent of MCO and 22.3 percent of BHO members). Within this group:
    - Four in ten caregivers (43.1 percent) thought their child still needed counseling or treatment at the time the benefits were used up (36.6 percent of MCO and 48.1 percent of BHO members).
        - More than half of caregivers (54.7 percent) who thought their child still needed counseling or treatment were told about other ways to get counseling, treatment, or medicine for their child (57.1 percent of MCO and 53.3 percent of BHO members).

Getting Treatment and Information

The mean rating for the *Getting Treatment and Information* composite for MCO members was 2.3 (SE = 0.1; Lower CL = 2.1, Upper CL = 2.6) and for BHO members was 2.1 (SE = 0.1; Lower CL = 1.8, Upper CL = 2.3), keeping in mind that only two of the six items pertained to BHOs. As shown in **Figure 4**, the majority (57 percent to 79 percent) of caregivers said that it was “not a problem” getting treatment information and assistance, with one exception for MCO members. Only one-third (35.6 percent) of caregivers whose child received care through an MCO “did not have a problem” with delays in counseling or treatment while awaiting approval from their child’s health plan. Thirty percent said it was a “big problem” and 34.4 percent said it was a “small problem."

Figure 4. Percentage of Caregivers Who Stated It Was "Not a Problem" Getting Treatment and Information for Their Child in STAR



Caregivers' Ratings of Their Child's MCO or BHO

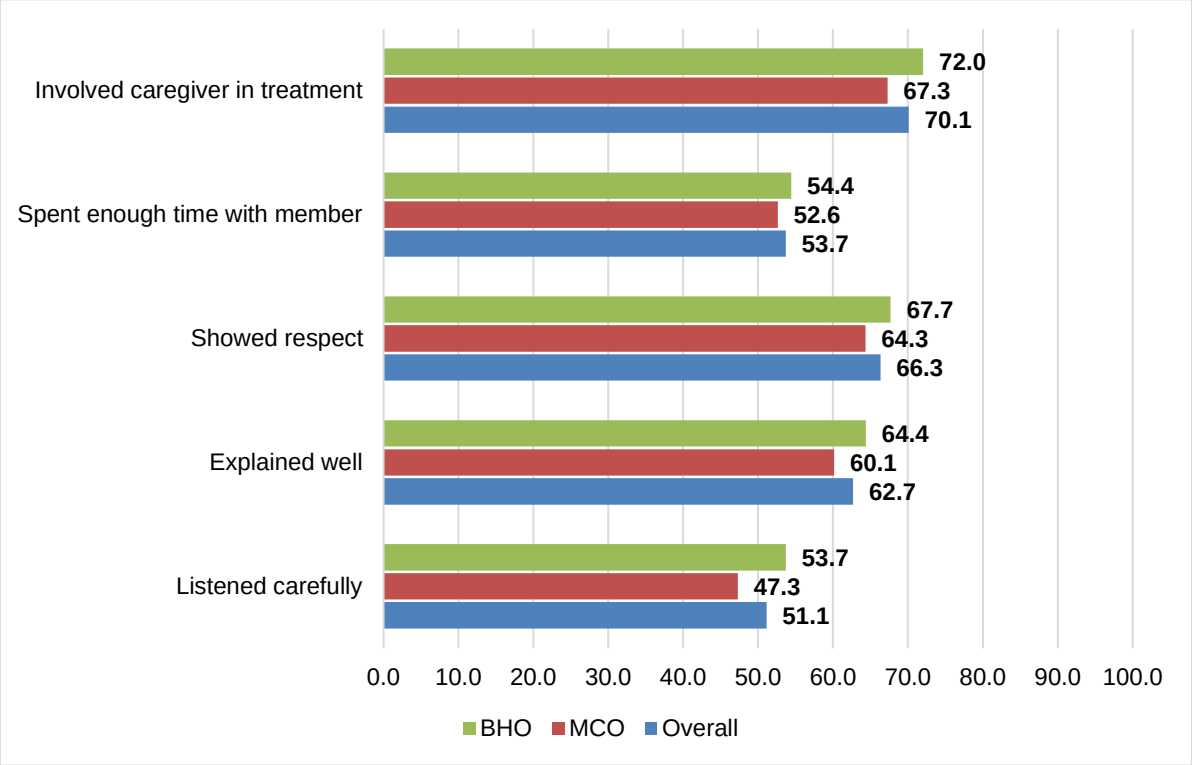
Caregivers of children belonging to an MCO were asked to provide an overall rating of their child's MCO in relation to counseling or treatment on a scale from 0 (worst plan possible) to 10 (best plan possible). Two-thirds (68.5 percent) of caregivers gave a rating of either "9" or "10"; the mean rating was 8.8 (SE = 0.1; Lower CL = 8.6, Upper CL = 9.1). Caregivers of children belonging to a BHO were asked to provide an overall rating of the company that handles their child's benefits for counseling or treatment on a scale from 0 (worst company possible) to 10 (best company possible). Two-thirds (66.6 percent) of caregivers gave a rating of either "9" or "10"; the mean rating was 8.5 (SE = 0.1; Lower CL = 8.2, Upper CL = 8.7).

4.1.6. Experiences with Clinicians and Health Plan

How Well Clinicians Communicate

The mean rating for the *How Well Clinicians Communicate* composite was 2.3 (SE = 0.0; Lower CL = 2.3, Upper CL = 2.4) overall, 2.3 (SE = 0.1; Lower CL = 2.2, Upper CL = 2.4) for MCO members, and 2.4 (SE = 0.0; Lower CL = 2.3, Upper CL = 2.5) for BHO members. Regarding the individual items that make up the composite, the majority of caregivers overall reported that clinicians "always" communicated well in multiple domains.

Figure 5. Percentage of Caregivers Who Said Their Child's Clinician in STAR "Always" Communicated Well, by Type of Communication



Information from Clinicians

Caregivers were asked a series of questions about whether they were given information in the past 12 months regarding their child's counseling or treatment:

- 82.9 percent said the goals of their child's counseling or treatment were completely discussed (79.4 percent in MCO, 85.2 percent in BHO).
- 73.6 percent said they were given as much information as they wanted about what they could do to manage their child's condition (69.6 percent in MCO, 76.3 percent in BHO).
- 77.8 percent felt they could refuse a specific type of medicine or treatment for their child (76.4 percent in MCO, 78.7 percent in BHO).

One ECHO® survey item summarized the *Information about Treatment Options* measure; 64.0 percent of caregivers agreed that the clinician or therapist informed them about the different kinds of counseling or treatment available for their child (61.9 percent of MCO and 65.4 percent of BHO members).

Patient Rights and Privacy

The majority (80.4 percent) of caregivers said they were given information about their child's rights as a patient (76.3 percent of MCO and 83.1 percent of BHO members). Additionally, 93.5 percent of caregivers thought their child's clinician did not share private information about their child's treatment or counseling with others (94.3 percent of MCO and 93.0 percent of BHO members).

Cultural Competence

Almost all (95.5 percent) of the caregivers thought child's race/ethnicity, culture, or religion did not make any difference in the kind of counseling or treatment he or she needed (95.9 percent of MCO and 95.2 percent of BHO members). Among caregivers who indicated their child's race/ethnicity, culture, or religion did make a difference (4.5 percent), 75.4 percent reported that the care their child received was responsive to those needs (92.6 percent of MCO and 66.4 percent of BHO members).

4.1.7. Perceived Outcomes of Behavioral Health Counseling and Treatment

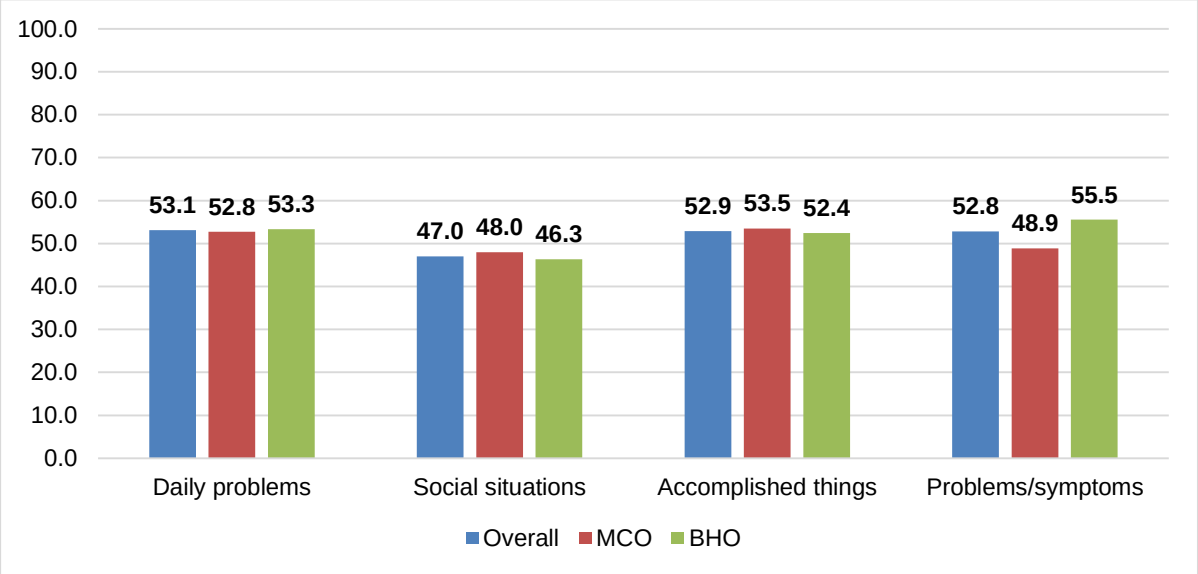
How Much Child in STAR Has Been Helped

To fully assess the quality of behavioral health counseling or treatment for children in STAR, caregivers were asked to rate how much their child had been helped by the counseling or treatment he or she received in the past 12 months. Half (50.0 percent) of caregivers said that the child had been helped "a lot" (46.3 percent of MCO and 52.4 percent of BHO members).

Perceived Improvement

The mean rating for the *Perceived Improvement* composite was 3.2 (SE = 0.0; Lower CL = 3.2, Upper CL = 3.3) overall, 3.2 (SE = 0.1; Lower CL = 3.1, Upper CL = 3.3) for MCO members, and 3.2 (SE = 0.0; Lower CL = 3.2, Upper CL = 3.3) for BHO members. Regarding the individual items that make up the composite, **Figure 6** shows that about half of caregivers reported their child was "much better" compared to 12 months ago in all domains.

Figure 6. Percentage of Caregivers Who Reported their Child in STAR Was "Much Better" Compared to 12 Months Ago, by Improvement Domain



4.1.8. Summary and Recommendations for STAR Child

Three-quarters or more of caregivers of STAR child members:

- Provided high overall ratings of their child's counseling or treatment as well as their child's health plan (mean of 8 on a scale from 0-10).
- Said they were given information in the past 12 months regarding their child's counseling or treatment.
- Thought their patient rights and privacy were protected.
- Gave high ratings regarding cultural competence.

Half of caregivers of STAR child members:

- Thought their child had improved "a lot" by counseling or treatment and was "much better" compared to one year ago.

The EQRO recommends that STAR MCOs assess the experiences of the one quarter of children whose caregivers reported lower ratings of counseling or treatment their child received or of the health plan in general. MCOs should identify common themes across these experiences to improve quality and provision of behavioral health care, which is also a goal of the Delivery System Reform Incentive Program (DSRIP) initiative.[38] Additionally, this effort should involve identifying the needs of the half of child members whose caregivers did not report "a lot" of improvement or that the child was "much better." For example, focus studies with caregivers and children can be conducted to discover barriers to children's greater

behavioral health improvement. Results can then be used to design and tailor interventions to address particular needs.

More than one-third of children in STAR were considered obese.

Half or less of caregivers of STAR child members:

- Rated their child's overall and mental health as "excellent."
- "Always" had access to counseling or treatment when they wanted or needed it (e.g., phone counseling, appointment available).
- Reported "big problems" with delays in counseling or treatment for their child as a result of awaiting approval from their health plan.
- Experienced poor communication with clinicians regarding how well they listen and how much time they spend with them.
- Thought their child still needed counseling or treatment among those whose benefits were used up (23 percent had used up their benefits).

The EQRO recommends that STAR MCOs continue comprehensive intervention efforts that prevent, identify, and address childhood obesity;[39] childhood obesity is linked to quality of life and physical and mental well-being.[40] Health interventions should consider multiple domains such as a focus on exercise, a healthy lifestyle, and the environment including access to healthy foods in school and at home.[41] Further, MCOs should provide adequate and timely access to behavioral health counseling or treatment. This is particularly important for child members because they experience rapid growth and associated physical and psychological changes. Additionally, efforts should target improving interactions between caregivers, children, and clinicians, which can be accomplished, for example, by using information published by the Agency for Healthcare Research and Quality (AHRQ) on improving communication between clinicians and patients.[42] MCOs should increase care coordination for behavioral health that is being offered, to different extents, by all MCOs according to findings from previous administrative interviews.[43] This will help improve caregiver and children's care experiences (e.g., timeliness of care, provision of behavioral health care).

The EQRO found no significant differences in caregiver ratings between those whose children received behavioral health care through an MCO compared to those who received care through a BHO. This suggests that experiences and satisfaction with behavioral health care and outcomes found in this study are similar regardless of the delivery model.

4.2. STAR Adult Behavioral Health Survey

This section presents survey findings on STAR adult members pertaining to their: (1) demographic characteristics, (2) health status, (3) use of behavioral health counseling and treatment, (4) access to and timeliness of behavioral health care, (5) behavioral health treatment benefits and assistance, (6) experiences with clinicians and health plans, and (7) perceived outcomes of behavioral health counseling and treatment.

Results are presented for STAR adult member reports overall and by delivery model (MCO compared to BHO). Unless indicated, there were no statistically significant differences in reports between members who received behavioral health care through an MCO compared to a BHO.

4.2.1. Demographic Characteristics of STAR Adult Members (N = 642)

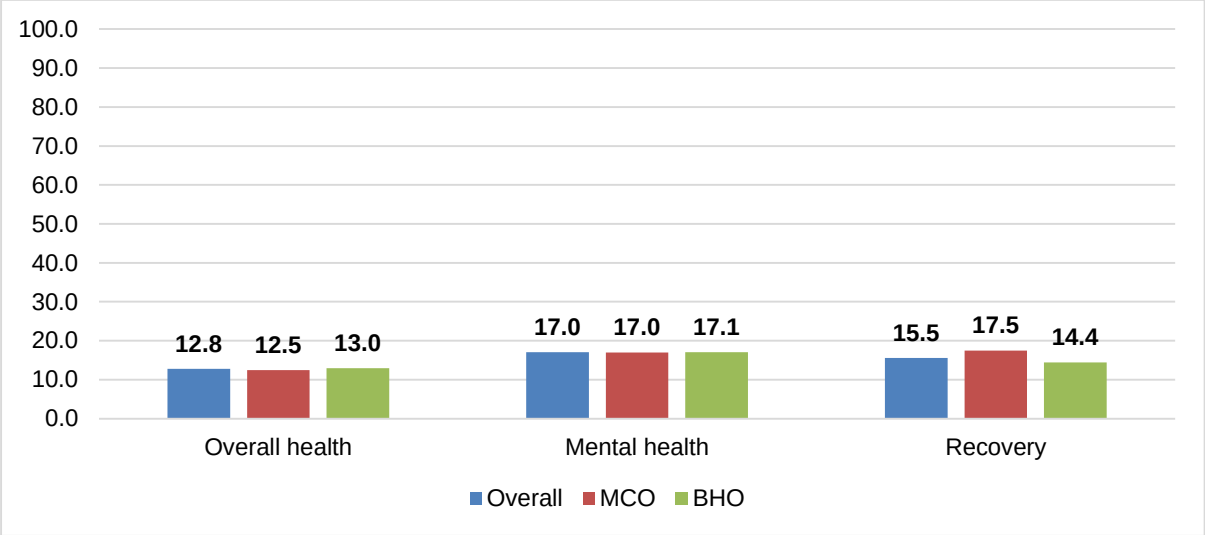
- The majority of STAR adult members were female (86.7 percent).
- Almost half identified as Hispanic (43.5 percent), 31.9 percent as White, non-Hispanic, 19.1 percent as Black, non-Hispanic, and 5.6 percent as “other race, non-Hispanic” which includes American Indian/Alaska Native and Asian/Pacific Islander.
- Eight in ten members were currently unemployed (79.3 percent); 69.7 percent had not been employed for the past 6 months.
- One in six was either married or unmarried with a partner (16.5 percent), more than half were single (57.8 percent), and one-quarter were divorced, separated, or widowed (25.7 percent).
- Most members described their households as single-parent households (70.2 percent) and one-quarter (25.3 percent) as two-parent households.
- Four in ten members had completed high school (43.1 percent), 27.8 percent had not completed high school, one-quarter had some college or a 2-year degree (25.1 percent), and 4.0 percent had completed a 4-year college degree or more.
- Most members spoke English at home (89.7 percent) and 9.3 percent spoke Spanish at home.
- Members were on average 34 years old (SE = 0.5; Lower CL = 33.1, Upper CL = 34.9; range 18-63 years).

4.2.2. Health Status

Overall Health, Mental Health, and Recovery

Only one in 10 (12.8 percent) members rated their overall health as “excellent”, 12.9 percent were in “very good” overall health, 27.6 percent said “good”, 28.4 percent said “fair”, and 18.3 said that they were in overall “poor” health. For mental health, 17.0 percent of members rated their mental health as “excellent”, 18.7 percent as “very good”, 26.3 percent as “good”, 30.3 percent as “fair”, and 7.6 percent as “poor.” Pertaining to their recovery from substance use disorders, 15.5 percent rated their recovery as “excellent”, 20.4 percent as “very good”, 27.0 percent as “good”, 27.2 percent as “fair” and 9.8 percent as “poor."

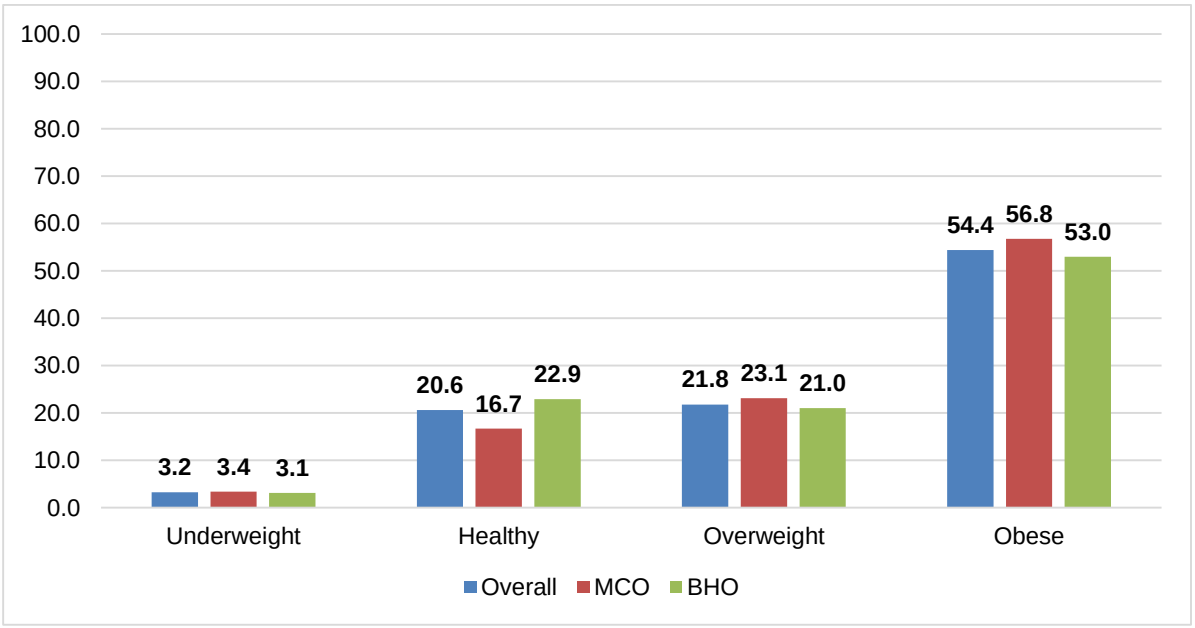
Figure 7. Percent of STAR Adult Members Giving an "Excellent" Rating on Their Overall Health, Mental Health, and Recovery Overall and by Delivery Model



Body Mass Index

Based on their self-report height and weight data, 3.2 percent of STAR adult members were underweight, 20.6 percent were at a healthy weight, 21.8 percent were overweight, and 54.4 percent were obese (**Figure 8**).

Figure 8. STAR Adult Body Mass Index Classification: Overall and by Delivery Model



4.2.3. Utilization of Behavioral Health Counseling and Treatment

This section provides results for STAR adult members' reports of their utilization of behavioral health counseling and treatment.

STAR adult members reported whether in the past 12 months they:

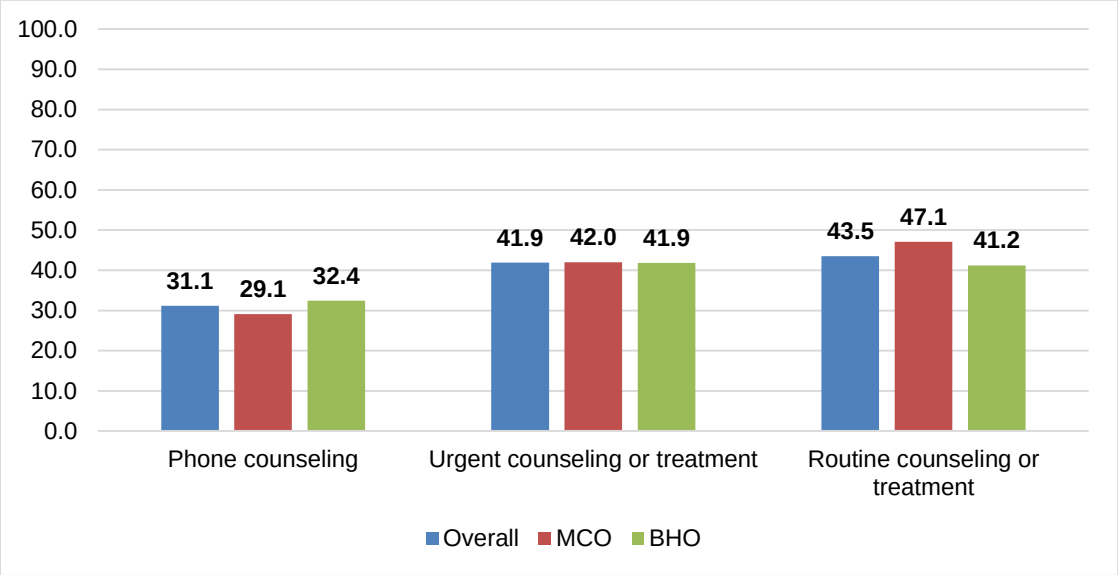
- Received counseling or treatment for personal problems, family problems, emotional illness, or mental illness (75.5 percent overall; 76.5 percent of MCO and 74.9 percent of BHO members).
- Received counseling or treatment for help with alcohol use or drug use (6.1 percent overall; 5.2 percent of MCO and 6.7 percent of BHO members).
- Went to an emergency department or crisis center to get counseling or treatment one or more times (32.2 percent overall; 32.6 percent of MCO and 32.0 percent of BHO members).
- Received counseling, treatment, or medicine at home, or in an office, clinic, or other treatment program one or more times (79.2 percent overall; 80.9 percent of MCO and 78.2 percent of BHO members).
- Took prescription medicine as part of their treatment (71.7 percent overall; 72.8 percent of MCO and 71.1 percent of BHO members). Of those,
  - 79.6 percent were told what side effects to watch for (76.5 percent of MCO and 81.4 percent of BHO members).
  - 45.4 percent experienced side effects from these medications (43.4 percent of MCO and 46.7 percent of BHO members).
  - 67.8 percent changed medicines to reduce these side effects (63.7 percent of MCO and 70.1 percent of BHO members).

4.2.4. Access to and Timeliness of Behavioral Health Care

Getting Treatment Quickly

The mean ECHO® score for the composite was 2.0 (SE = 0.1; Lower CL = 1.9, Upper CL = 2.1) overall, 2.0 (SE = 0.1; Lower CL = 1.9, Upper CL = 2.2) for MCO members, and 2.0 (SE = 0.1; Lower CL = 1.9, Upper CL = 2.1) for BHO members. Regarding the individual items that made up the composite, 41.9 percent of members "always" got an appointment for urgent professional counseling or treatment as soon as they wanted; 43.5 percent of members "always" got a routine appointment for counseling or treatment as soon as they wanted; and 31.1 percent "always" got professional counseling over the telephone when needed (16.0 percent called someone to get professional counseling on the phone).

Figure 9. Percent of STAR Adult Members Reporting "Always" Receiving Behavioral Health Treatment When Needed, by Type of Care



Office Wait

STAR adult members also reported how often they were seen within 15 minutes of their appointment in the past 12 months. Less than one-third (29.0 percent) of members were "always" seen within 15 minutes (31.5 percent of MCO and 27.5 percent of BHO members).

Rating of Counseling or Treatment

When STAR adult members rated their overall perceptions of their counseling or treatment on a scale from 0 (lowest) to 10 (highest), 43.1 percent gave a rating of either "9" or "10" (42.9 percent of MCO and 43.3 percent of BHO members). The mean rating of counseling or treatment was 7.6 (SE = 0.1; Lower CL = 7.4, Upper CL = 7.8) overall, 7.6 (SE = 0.2; Lower CL = 7.3, Upper CL = 7.9) for MCO, and 7.6 (SE = 0.1; Lower CL = 7.3, Upper CL = 7.9) for BHO members.

4.2.5. Behavioral Health Treatment Benefits and Assistance

This section provides results for STAR adult members' experiences with their MCO or their BHO regarding available behavioral health benefits for counseling and treatment and clinician assistance.

Extended Benefits

Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.[44] STAR adult members were asked whether they had used up all of their

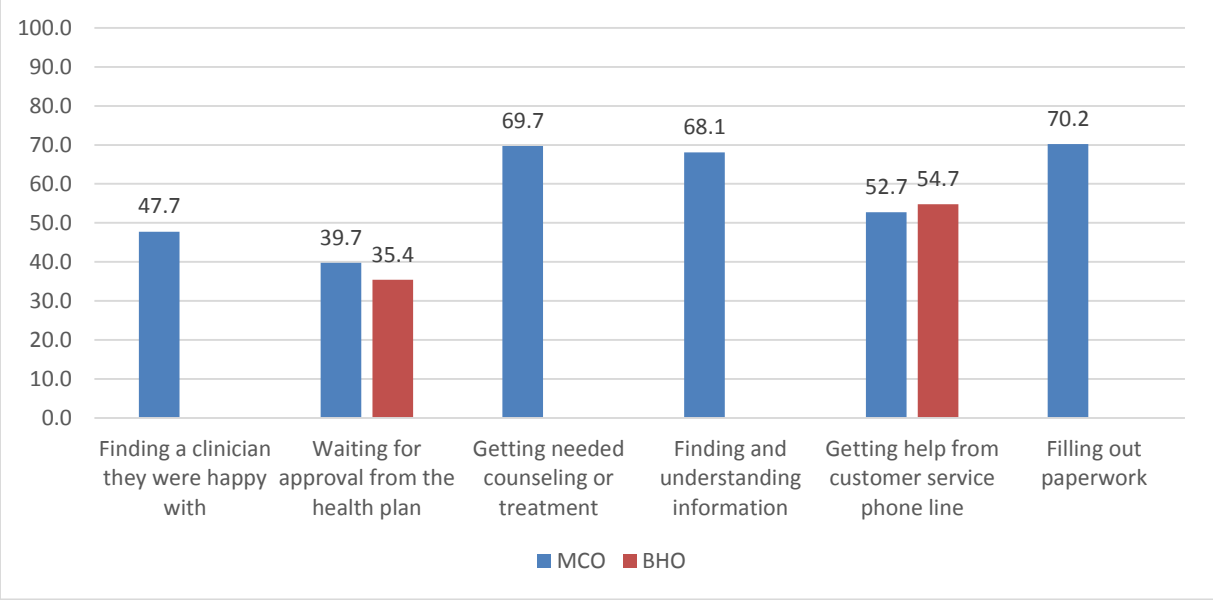
benefits for counseling and treatment in the last 12 months and if so, whether they were still in need of counseling or treatment.

- One in five (21.3 percent) members had used up all benefits for counseling or treatment in the past 12 months (24.1 percent of MCO and 19.7 percent of BHO members). Within this group:
  - 62.3 percent thought they were still in need of counseling or treatment at the time the benefits were used up (70.7 percent of MCO and 56.6 percent of BHO members).
    - 50.5 percent of those who thought they still needed counseling or treatment were told about other ways to get counseling, treatment, or medicine (48.6 percent of MCO and 52.3 percent of BHO members).

Getting Treatment and Information

The mean for the composite *Getting Treatment Information* was 2.2 (SE = 0.1; Lower CL = 2.1, Upper CL = 2.4) for MCO members and 1.8 (SE = 0.1; Lower CL = 1.5, Upper CL = 2.1) for BHO members, keeping in mind that only two of the six items pertained to BHOs. Thus, findings in **Figure 10** for BHO members only apply to "waiting for approval from the health plan" and "getting help from customer service phone line." As shown in **Figure 10**, the majority of STAR adult members generally said it was "not a problem" getting treatment information and assistance, with two exceptions. More than half of MCO members had a problem finding someone they were happy with and approximately six in ten MCO and BHO members had a problem with delays in counseling or treatment while awaiting approval from their health plan.

Figure 10. Percentage of STAR Adult Members Who Stated It Was "Not a Problem" Getting Treatment and Information



STAR Adult Members' Ratings of Their MCO or BHO

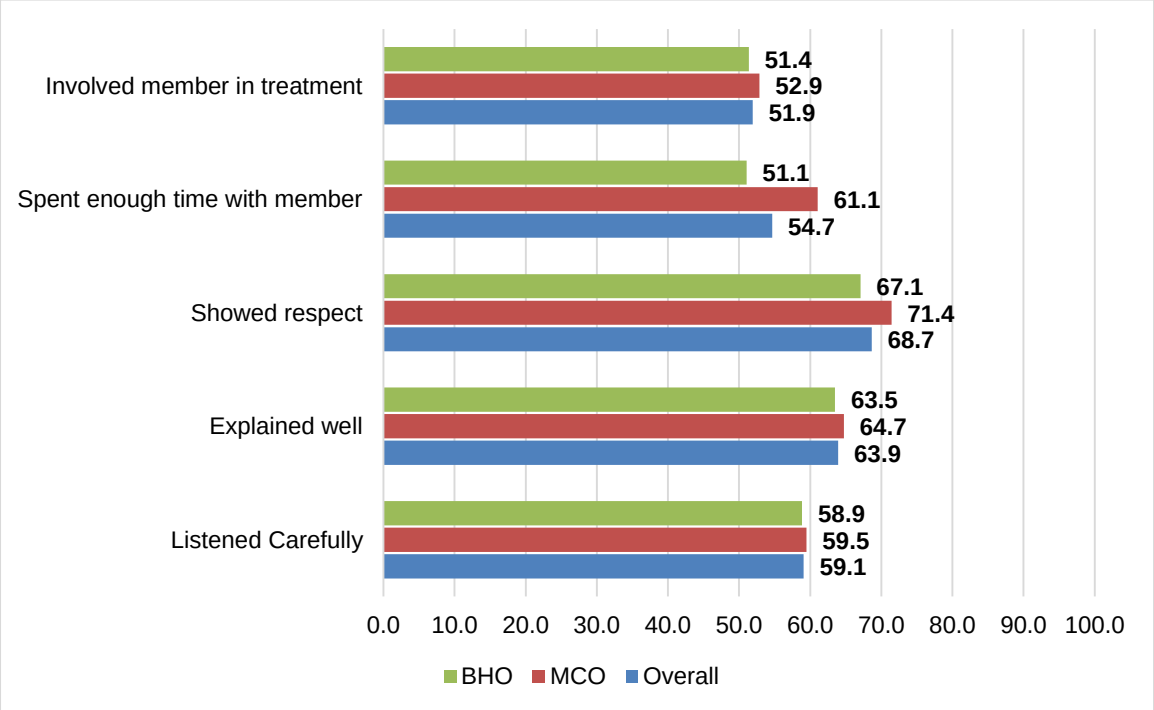
Members belonging to an MCO were asked to provide an overall rating of their MCO in relation to counseling or treatment on a scale from 0 (worst plan possible) to 10 (best plan possible); 60.3 percent gave a rating of either "9" or "10" with a mean rating of 8.3 (SE = 0.1; Lower CL = 8.0, Upper CL = 8.6). Members belonging to a BHO were asked to provide an overall rating of the company that handles their benefits for counseling or treatment on a scale from 0 (worst company possible) to 10 (best company possible); 57.7 percent gave a rating of either "9" or "10" with a mean rating of 8.1 (SE = 0.1; Lower CL = 7.8, Upper CL = 8.4).

4.2.6. Experiences with Clinicians and Health Plan

How Well Clinicians Communicate

The mean for the composite *How Well Clinicians Communicate* was 2.4 (SE = 0.0; Lower CL = 2.3, Upper CL = 2.5) overall, 2.4 (SE = 0.0; Lower CL = 2.4, Upper CL = 2.5) for MCO members, and 2.4 (SE = 0.0; Lower CL = 2.3, Upper CL = 2.4) for BHO members. As seen in **Figure 11**, the majority of STAR adult members reported that clinicians "always" communicated well in multiple domains.

Figure 11. Percentage of STAR Adult Members Who Said Their Clinician "Always" Communicated Well, by Type of Communication



Information from Clinicians

The mean for the composite *Information about Treatment Options* was 0.5 (SE = 0.0; Lower CL = 0.4, Upper CL = 0.5) overall, 0.4 (SE = 0.0; Lower CL = 0.4, Upper CL = 0.5) for MCO members, and 0.5 (SE = 0.0; Lower CL = 0.4, Upper CL = 0.5) for BHO members. For the individual items that made up the composite:

- 54.9 percent were informed about different kinds of counseling or treatment available (49.3 percent of MCO and 58.2 percent of BHO members).
- 39.8 percent were told about self-help or support groups (37.9 percent of MCO and 41.0 percent of BHO members).

Additionally:

- 73.3 percent were given as much information as they wanted about what they could do to manage their condition (69.6 percent of MCO and 75.5 percent of BHO members).
- 81.7 percent felt they could refuse a specific type of medicine or treatment (79.2 percent of MCO and 83.2 percent of BHO members).

Patient Rights and Privacy

The vast majority (85.1 percent) of members were given information about their rights as a patient (84.6 percent of MCO and 85.4 percent of BHO members). Similarly, 93.0 percent of members thought that their clinician did not share private information about their counseling or treatment with others (93.0 percent of MCO and 92.9 percent of BHO members).

Cultural Competence

Almost all (93.5 percent) of the members thought that their race/ethnicity, culture, or religion did not make any difference in the kind of counseling or treatment they needed (96.6 percent of MCO and 91.7 percent of BHO members). Among members who indicated their race/ethnicity, culture, or religion did make a difference (6.5 percent), 61.1 percent reported that the care they received was responsive to those needs (37.8 percent of MCO and 66.5 percent of BHO members).

4.2.7. Perceived Outcomes of Behavioral Health Counseling and Treatment

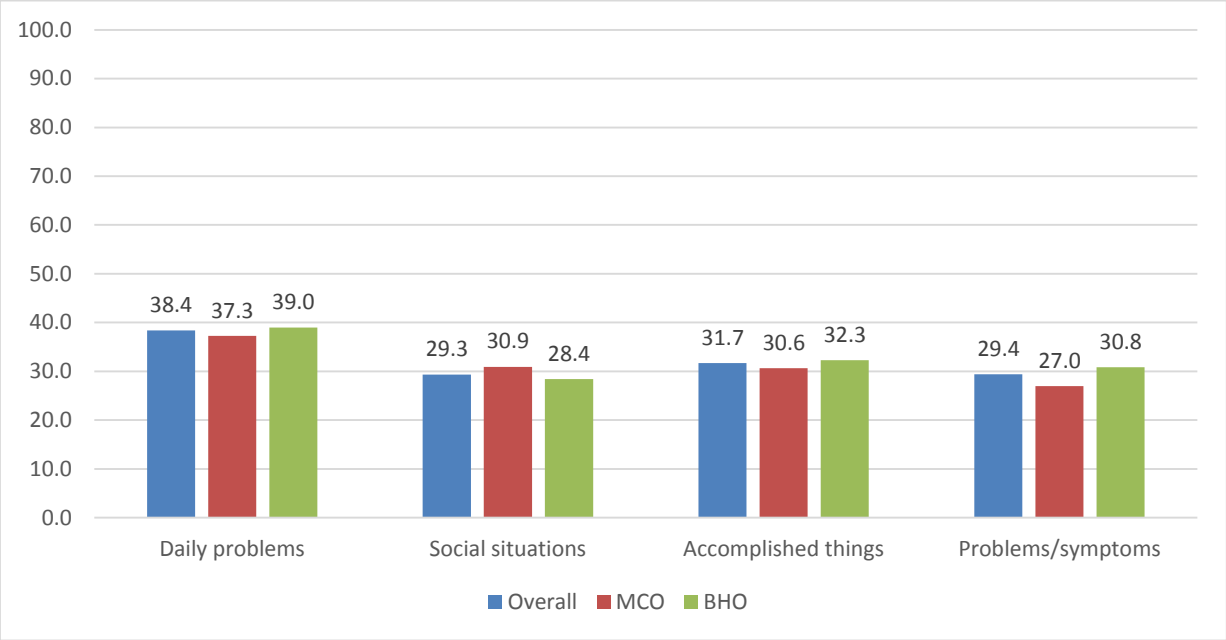
How Much the STAR Adult Member Has Been Helped

Members were asked to rate how much they had been helped by the counseling or treatment they received in the past 12 months; 47.8 percent of members were helped “a lot” (46.0 percent of MCO and 48.9 percent of BHO members). Additionally, members were asked to rate how much the counseling or treatment had impacted the quality of their life; 51.9 percent said that counseling or treatment was “very helpful” regarding their quality of life (51.2 percent of MCO and 52.3 percent of BHO members).

Perceived Improvement

The mean for the composite *Perceived Improvement* was 2.8 (SE = 0.0; Lower CL = 2.7, Upper CL = 2.8) overall, 2.7 (SE = 0.1; Lower CL = 2.6, Upper CL = 2.8) for MCO members, and 2.8 (SE = 0.1; Lower CL = 2.7, Upper CL = 2.9) for BHO members. Regarding the individual items that make up the composite, one third of STAR adult members thought they were "much better" compared to 12 months ago in all domains (**Figure 12**).

Figure 12. Percentage of STAR Adult Members Who Reported They Were "Much Better" Compared to 12 Months Ago, by Improvement Domain



4.2.8. Summary and Recommendations for STAR Adult

- Three-quarters or more of STAR adult members:
  - Received information from their clinician about managing their mental health condition.
  - Felt they could refuse medication or treatment for their mental health condition.
  - Reported that when taking medication for mental health disorders, their clinician informed them of possible side effects and changed medications in the event of negative outcomes.

The EQRO recommends that STAR MCOs continue to improve communication between STAR adult members and clinicians, especially for those members who did not receive information on how to manage their mental health condition. AHRQ, for instance, provides tips for patients and clinicians on how to improve their communication.[45] Additionally, AHRQ offers advice for patients on how to be more involved in their care (e.g., questions to ask, how to prepare for an appointment) and make better decisions about the care they receive.[46]

- Half of STAR adult members were obese.
- Less than one in five members rated their overall health, mental health, and recovery from substance use disorders as “excellent.”

MCOs should provide health intervention programs that address the specific needs of STAR adult members with behavioral health disorders because they have an increased risk of being overweight and being obese.[47] Weight gain, for example, is associated with certain medications for the treatment of mental health disorders (e.g., antipsychotics, antidepressants).[48] Subsequent medication-related weight gain is also associated with patients’ lack of medication compliance,[49] increasing the risk of worsening mental health disorders that can also negatively affect other outcomes such as overall well-being.

- One-third of members thought they were “much better” in dealing with daily problems, social situations, accomplishing things, and problems/symptoms compared to one year ago.
- Less than half of members:
  - Could get treatment quickly.
  - Thought that counseling and treatment helped them “a lot."
- One-quarter of members used up their benefits for counseling or treatment; of those:
  - 60 percent thought they still needed counseling or treatment.
    - 50 percent of those who thought they still needed counseling or treatment were told of other treatment options.

MCOs should conduct focus studies with STAR adult members who did not greatly improve over the past 12 months to identify barriers (e.g., personal, MCO, provider) they may be facing to better health outcomes. Efforts should aim to increase MCOs’ implementation of health promotion programs in STAR specific to behavioral health to improve members’ access to counseling or treatment (e.g., after benefits are used up, getting treatment quickly) and patient outcomes. Results from prior administrative interviews showed that only 53 percent of MCOs included substance abuse management, 47 percent obesity prevention, 68 percent weight management, and 74 percent physical activity,[50] all of which are important to members with behavioral health disorders. Additionally, MCOs should assure that services and programs offer a component that is applicable to adults, as many MCOs from this prior administrative interview noted that over 90 percent of their members were children.

The EQRO found no significant differences in STAR adult member ratings between those who received behavioral health care through an MCO compared to a BHO, indicating that experiences and satisfaction with behavioral health care and outcomes found in this study are similar regardless of the delivery model.

4.3. STAR+PLUS Adult Behavioral Health Survey

This section presents survey findings on STAR+PLUS adult members pertaining to their: (1) demographic characteristics, (2) health status, (3) utilization of behavioral health counseling and treatment, (4) access to and timeliness of behavioral health care, (5) behavioral health treatment benefits and assistance, (6) experiences with clinicians and health plans, (7) perceived outcomes of behavioral health counseling and treatment, and awareness of and experiences with service coordination. It is imperative to highlight that the STAR+PLUS population is not necessarily comparable to the national Medicaid population because STAR+PLUS serves individuals who are elderly and/or disabled; high rates of utilization and other indicators of greater health care needs are expected. Results are presented for STAR+PLUS adult member reports overall and by delivery model (MCO and BHO). It is important to also note here that all STAR+PLUS members receiving behavioral health care through a BHO were located in the Dallas SA. Thus, comparisons by delivery model are essentially made between the Dallas (BHO) SA and other SAs (MCOs). Unless indicated, there were no statistically significant differences in reports between members who received behavioral health care through an MCO compared to a BHO.

4.3.1. Demographic Characteristics of STAR+PLUS Adult Members (N=1,483)

- The majority of STAR+PLUS adult members were female (63.8 percent).
- One-third identified as Hispanic (32.7 percent), 32.9 percent as White, non-Hispanic, 28.3 percent as Black, non-Hispanic, and 6.1 percent as “other race, non-Hispanic” which includes American Indian/Alaska Native and Asian/Pacific Islander.
- Almost all members were currently unemployed (96.4 percent); 94.9 percent had not been employed for the past 6 months.
- Half were single (48.7 percent), 13.9 percent were either married or unmarried with a partner, and 37.4 were divorced, separated, or widowed.
- One-third of members described their households as a single-parent household (30.1 percent), 11.2 percent as a two-parent household, 24.6 percent as non-parents, and 34.1 percent as parents without children living at home.
- One-third of members had completed high school (33.5 percent), 42.1 percent had not completed high school, 20.3 percent had some college or a 2-year degree, and 4.1 percent had completed a 4-year college degree or more.
- Most spoke English at home (90.1 percent) and 8.6 percent spoke Spanish at home.
- Members were on average 49.9 years old (SE = 0.3; Lower CL = 49.2, Upper CL = 50.5; range 18-64 years).

There were two significant differences in demographic characteristics between STAR+PLUS adult members who received behavioral health care through an MCO compared to a BHO. MCO compared to BHO members had a higher percentage of Hispanic members, a higher percentage of White, non-Hispanic members, and a lower percentage of Black, non-Hispanic

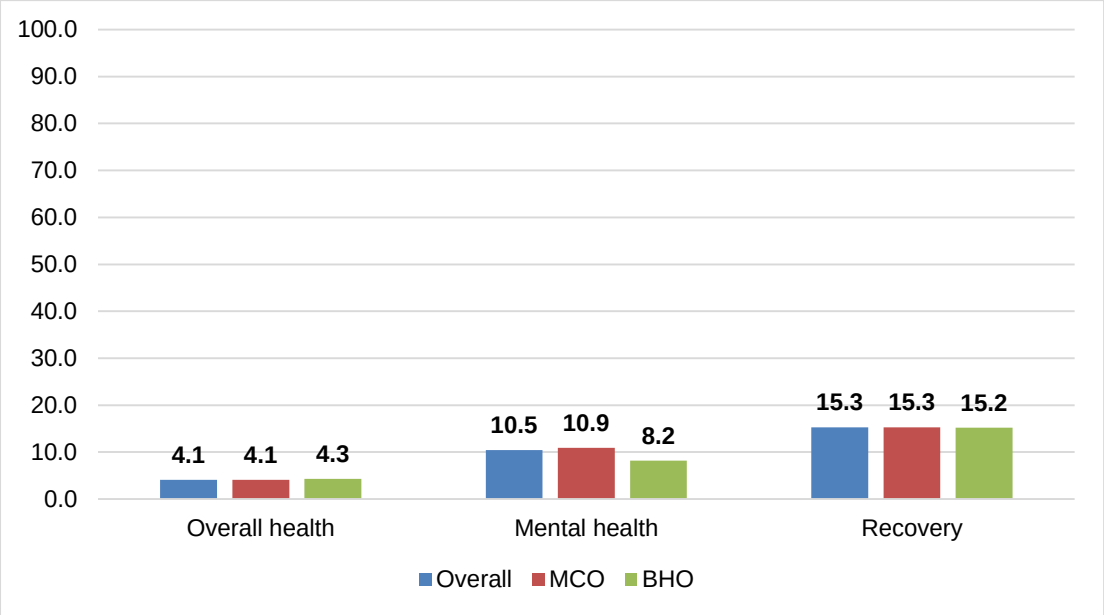
members. Consistent with this finding, fewer MCO than BHO members spoke English at home. These differences reflect the demographic characteristics of members receiving behavioral health care in the Dallas SA (BHO) compared to other SAs (MCO).

4.3.2. Health Status

Overall Health, Mental Health, and Recovery

Only 4.1 percent of STAR+PLUS adult members rated their overall health as “excellent”, 9.4percent said “very good”, 21.3 percent “good”, 38.7 percent “fair”, and 26.4 percent said that they were in “poor” overall health. For mental health, 10.5 percent of members rated their mental health as “excellent”, 18.3 percent as “very good”, 27.2 percent as “good”, 32.8 percent as “fair”, and 11.2 percent as “poor." Among those who received treatment for substance use disorders, 15.3 percent rated their recovery as “excellent”, 19.2 percent as “very good”, 25.1 percent as “good”, 28.1 percent as “fair”, and 12.3 percent as “poor” (**Figure 13**).

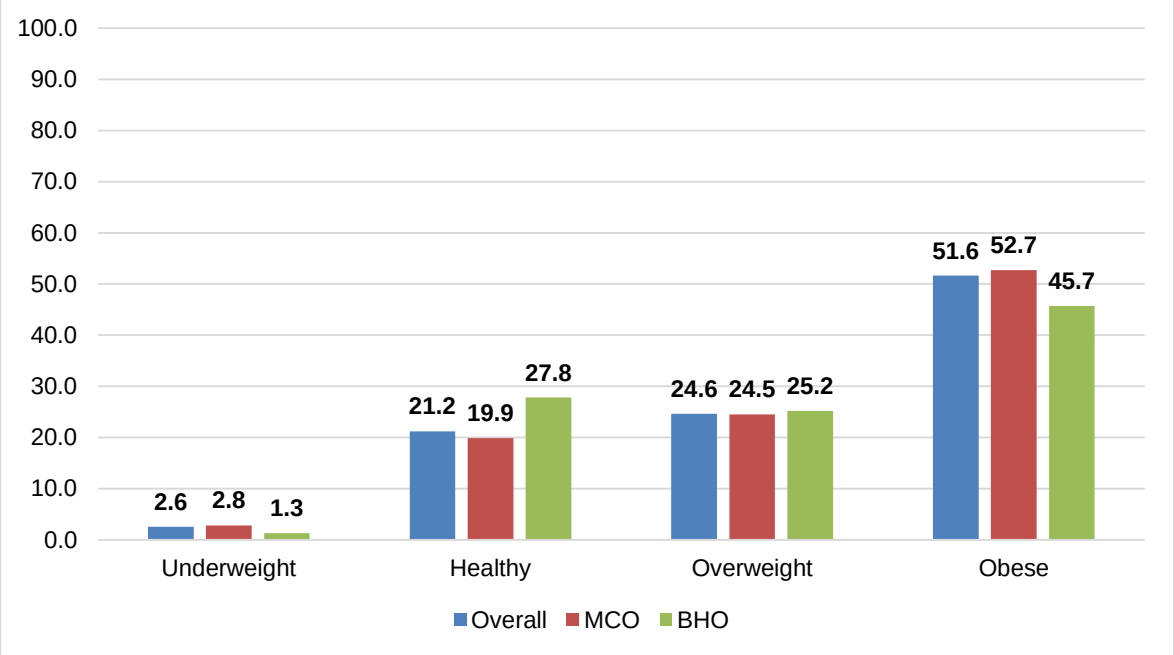
Figure 13. Percent of STAR+PLUS Adult Members Giving an “Excellent” Rating on Their Overall Health, Mental Health, and Recovery Overall and by Delivery Model



Body Mass Index

Based on their self-report height and weight data, 2.6 percent of STAR+PLUS adult members were underweight, 21.2 percent were at a healthy weight, 24.6 percent were overweight, and 51.6 percent were obese (**Figure 14**).

Figure 14. STAR+PLUS Adult Body Mass Index Classification: Overall and by Delivery Model



4.3.3. Utilization of Behavioral Health Counseling and Treatment

This section provides results for STAR+PLUS adult members' reports of their utilization of behavioral health counseling and treatment. STAR+PLUS adult members reported whether in the past 12 months they:

- Received counseling or treatment for personal problems, family problems, emotional illness, or mental illness (75.0 percent overall; 74.9 percent of MCO and 75.5 percent of BHO members).
- Received counseling or treatment for help with alcohol use or drug use (6.5 percent overall; 6.2 percent of MCO and 8.1 percent of BHO members).
- Went to an emergency department or crisis center to get counseling or treatment one or more times (38.3 percent overall; 37.8 percent of MCO and 40.9 percent of BHO members).
- Received counseling, treatment, or medicine at home, or in an office, clinic, or other treatment program one or more times (81.5 percent overall; 80.6 percent of MCO and 86.2 percent of BHO members).

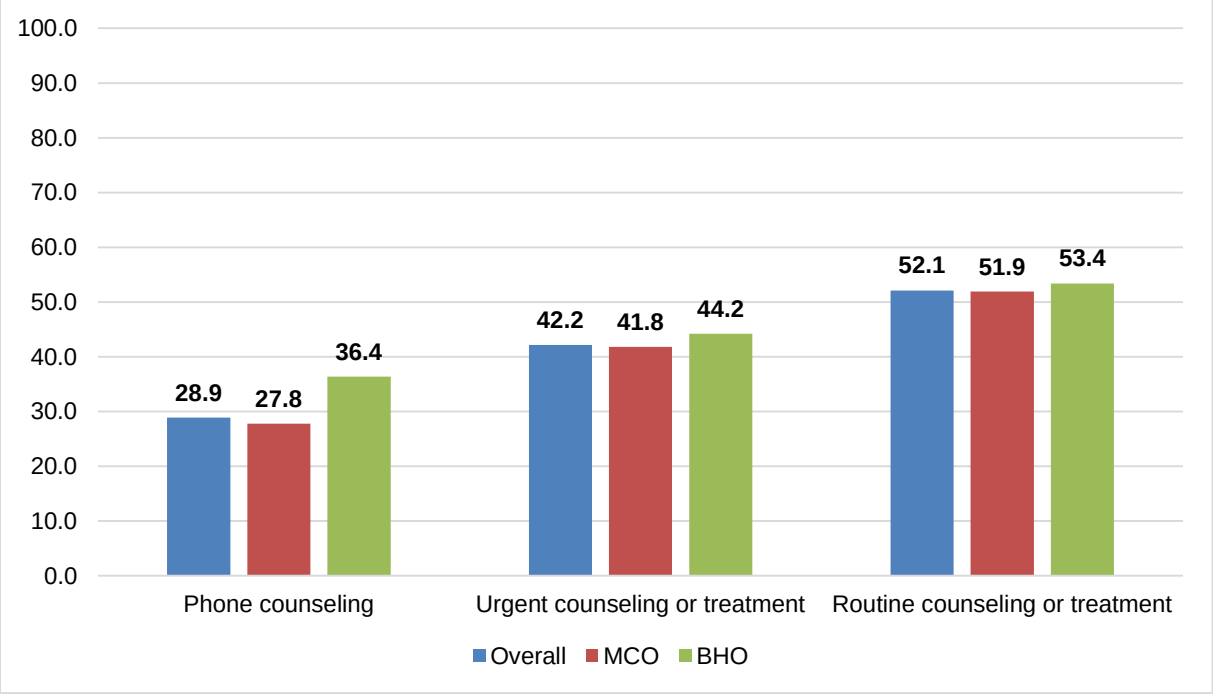
- Took prescription medicine as part of their mental health treatment (83.7 percent overall; 82.2 percent of MCO and 91.5 percent of BHO members. The difference in prescription medicine use between MCO and BHO members was statistically significant (p = .0006). Of those:
  - 76.4 percent were told what side effects to watch for (76.2 percent of MCO and 77.3 percent of BHO members).
  - 40.1 percent experienced side effects from these medications (40.9 percent of MCO and 36.0 percent of BHO members).
    - 67.9 percent changed medicines to reduce these side effects (68.0 percent of MCO and 67.6 percent of BHO members).

4.3.4. Access to and Timeliness of Behavioral Health Care

Getting Treatment Quickly

The mean for the composite *Getting Treatment Quickly* was 2.1 (SE = 0.0; Lower CL = 2.0, Upper CL = 2.1) overall, 2.0 (SE = 0.0; Lower CL = 2.0, Upper CL = 2.1) for MCO members, and 2.1 (SE = 0.1; Lower CL = 2.0, Upper CL = 2.3) for BHO members. Between one-third and one-half of STAR+PLUS adult members reported that they "always" got treatment quickly, with the lowest ratings pertaining to phone counseling and the highest ratings for getting an appointment as soon as they wanted (**Figure 15**).

Figure 15. Percent of STAR+PLUS Adult Members Reporting "Always" Receiving Behavioral Health Treatment When Needed, by Type of Care



Office Wait

STAR+PLUS adult members also reported how often they were seen within 15 minutes of their appointment in the past 12 months. One-third (32.0 percent) of members were “always” seen within 15 minutes (31.3 percent of MCO and 35.6 percent of BHO members).

Rating of Counseling or Treatment

When STAR+PLUS adult members rated their overall perceptions of their counseling or treatment on a scale from 0 to 10, with zero indicating low quality and 10 indicating high quality, 51.0 percent gave a rating of either “9” or “10” (51.6 percent of MCO and 48.1 percent of BHO members). The mean rate of counseling or treatment was 7.8 (SE = 0.1; Lower CL = 7.6, Upper CL = 7.9) overall, 7.8 (SE = 0.1; Lower CL = 7.6, Upper CL = 8.0) for MCO and 7.7 (SE = 0.2; Lower CL = 7.4, Upper CL = 8.0) for BHO members.

4.3.5. Behavioral Health Treatment Benefits and Assistance

This section provides results for STAR+PLUS adult members' experiences with their MCO or their BHO regarding available behavioral health benefits for counseling and treatment and clinician assistance.

Extended Benefits

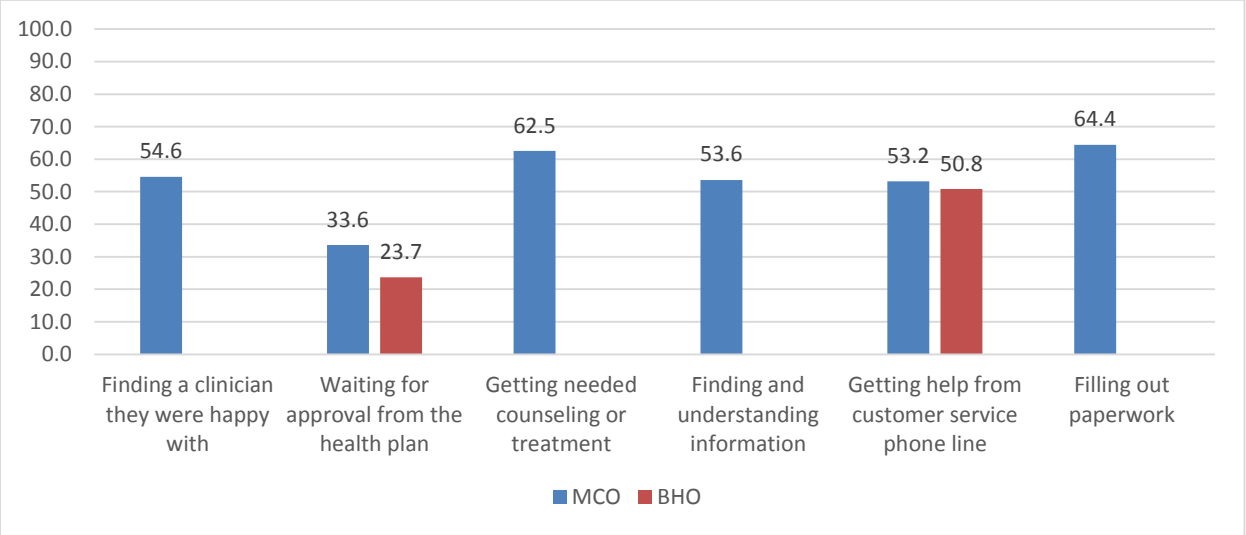
Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.[51] STAR+PLUS adult members were asked about whether or not they had used up all of their benefits for counseling and treatment in the last 12 months and whether or not they were still in need of counseling or treatment.

- One in five (21.9 percent) members reported they had used up all benefits for counseling or treatment in the past 12 months (23.2 percent of MCO and 15.1 percent of BHO members). Within this group:
  - 73.0 percent who thought they were still in need of counseling or treatment at the time the benefits were used up (74.0 percent of MCO and 64.5 percent of BHO members).
    - Half of the members (43.9 percent) who thought they were still in need of counseling or treatment were told about other ways to get counseling, treatment, or medicine (42.7 percent of MCO and 55.6 percent of BHO members).

Getting Treatment and Information

The mean rate for the composite *Getting Treatment Information* was 2.2 (SE = 0.0; Lower CL = 2.1, Upper CL = 2.3) for MCO members and 1.8 (SE = 0.1; Lower CL = 1.5, Upper CL = 2.1) for BHO members, keeping in mind that only two of the six items pertained to BHOs. Regarding the individual items, as shown in **Figure 16**, more than half (50.8 percent to 64.4 percent) of STAR+PLUS adult members said that it was “not a problem” getting treatment and information. However, only one-quarter of BHO members and one-third of MCO members did not have a problem with delays in counseling while awaiting approval from their health plan.

Figure 16. Percentage of STAR+PLUS Adult Members Who Stated It was "Not a Problem" Getting Treatment and Information



STAR+PLUS Adult Members' Ratings of Their MCO or BHO

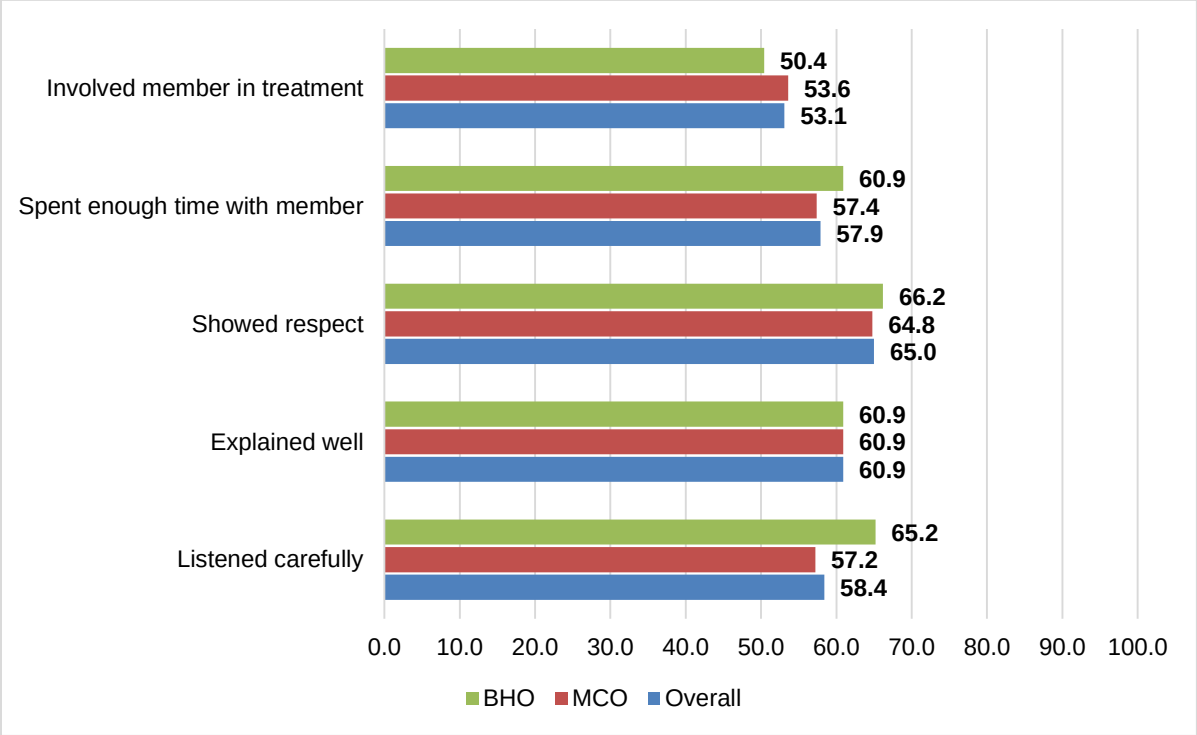
Members belonging to a MCO were asked to provide an overall rating of their MCO in relation to counseling or treatment on a scale from 0 (worst plan possible) to 10 (best plan possible); 60.1 percent gave a rating of either "9" or "10" with a mean rating of 8.2 (SE= 0.1; Lower CL = 8.0, Upper CL = 8.4). Members belonging to a BHO were asked to provide an overall rating of the company that handles their benefits for counseling or treatment on a scale from 0 (worst company possible) to 10 (best company possible); 58.2 percent gave a rating of either "9" or "10" with a mean rating of 8.1 (SE=0.2; Lower CL = 7.8, Upper CL = 8.5).

4.3.6. Experiences with Clinicians and Health Plan

How Well Clinicians Communicate

The mean rating for the composite *How Well Clinicians Communicate* was 2.4 (SE = 0.0; Lower CL = 2.3, Upper CL = 2.4) overall, and for both MCO and BHO members. For the individual items, the majority (50.4 percent to 66.2 percent) of STAR+PLUS adult members reported that clinicians "always" communicated well in multiple domains (**Figure 17**).

Figure 17. Percentage of STAR+PLUS Adult Members Who Said Their Clinician "Always" Communicated Well, by Type of Communication



Information from Clinicians

STAR+PLUS adult members were asked a series of questions about whether or not they were given information in the past 12 months regarding their counseling or treatment. Two ECHO® survey items summarized the *Information about Treatment Options*. The mean for the composite for *Information about Treatment Options* was 0.5 (SE = 0.0; Lower CL = 0.4, Upper CL = 0.5) overall, 0.5 (SE = 0.0, Lower CL = 0.4, Upper CL = 0.5) for MCO members and 0.5 (SE = 0.0; Lower CL = 0.5, Upper CL = 0.6) for BHO members.

- 40.9 percent were told about self-help or support groups (39.8 percent of MCO and 46.7 percent of BHO members).
- 53.2 percent were informed about different kinds of counseling or treatment available (52.8 percent of MCO and 55.1 percent of BHO members).
- 70.5 percent said they were given as much information as they wanted about what they could do to manage their condition (71.0 percent of MCO and 67.5 percent of BHO members).
- 76.5 percent felt they could refuse a specific type of medicine or treatment (76.9 percent of MCO and 74.3 percent of BHO members).

Patient Rights and Privacy

The majority (79.5 percent) of members were given information about their rights as a patient (79.7 percent in MCO, 78.2 percent in BHO). Similarly, 89.2 percent of members thought that their clinician did not share private information about their counseling or treatment with others (88.8 percent of MCO and 91.2 percent of BHO members).

Cultural Competence

Almost all (90.5 percent) of the STAR+PLUS members thought that their race/ethnicity, culture, or religion did not make any difference in the kind of counseling or treatment they needed (90.3 percent of MCO and 92.2 percent of BH members). Among members who indicated their race/ethnicity, culture, or religion did make a difference (9.5 percent), 65.3 percent reported that the care they received was responsive to those needs (66.1 percent of MCO and 58.8 percent of BHO members).

4.3.7. Perceived Outcomes of Behavioral Health Counseling and Treatment

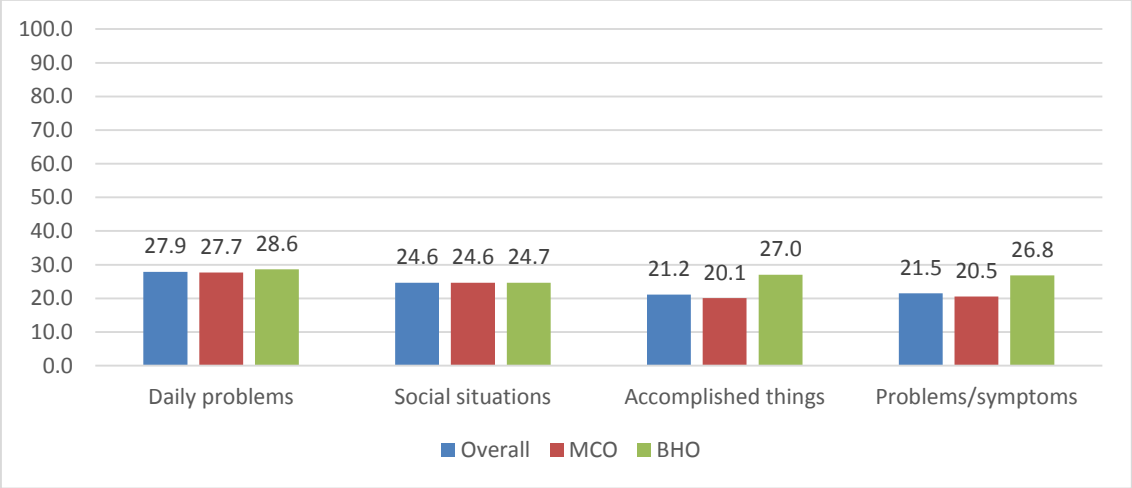
How Much the STAR+PLUS Adult Member Has Been Helped

Members were asked to rate how much they had been helped by the counseling or treatment they received in the past 12 months. Half (51.6 percent) of members were helped “a lot” (51.3 percent of MCO and 53.0 percent of BHO members). Additionally, 55.2 percent of members said that counseling or treatment was “very helpful” regarding their quality of life (54.9 percent of MCO and 56.4 percent of BHO members).

Perceived Improvement

The mean rating for the composite was 2.6 (SE = 0.0; Lower CL = 2.6, Upper CL = 2.7) overall, 2.6 (SE = 0.0; Lower CL = 2.5, Upper CL = 2.6) for MCO members, and 2.7 (SE = 0.1; Lower CL = 2.6, Upper CL = 2.8) for BHO members. One-quarter of STAR+PLUS adult members thought that they were “much better” compared to 12 months ago in all domains (**Figure 18**)

Figure 18. Percentage of STAR+PLUS Adult Members Who Reported They Were "Much Better" Compared to 12 Months Ago, by Improvement Domain



4.3.8. STAR+PLUS Adult Members' Awareness of and Experience with Service Coordination

Service coordinators are available to STAR+PLUS members, their families, and the members' physicians to provide help with the coordination of medical services and long-term services and supports.[52] STAR+PLUS members were asked about their awareness of service coordination and their subsequent experiences with these services.

Awareness and Utilization

Half of the members (55.3 percent) were aware that their health plan offered service coordination (55.5 percent of MCO and 54.3 percent of BHO members). Among those who were aware of service coordination, 51.9 percent had a service coordinator from their health plan who helped arrange medical and other types of services (51.9 percent of MCO and 51.7 percent of BHO members). Additionally, 60.6 percent of those who had a service coordinator reported that in the past six months they needed a service coordinator to help arrange services (61.9 percent of MCO and 53.4 percent of BHO members).

Experiences

Among members who needed help from service coordinators, only approximately half of them had positive experiences in the past six months:

- 48.4 percent "always" got help as soon as they needed it (47.4 percent of MCO and 54.8 percent of BHO members); 12.9 percent "usually" got help as soon as they needed it (13.9 percent of MCO and 6.5 percent of BHO members).
- 60.8 percent said that their service coordinator "always" explained things well (60.7 percent of MCO and 61.3 percent of BHO members); 8.6 percent said their service coordinator "usually" explained things well (7.4 percent of MCO and 16.1 percent of BHO members).

- 45.7 percent said that their service coordinator “always” involved them in decisions about services (44.8 percent of MCO and 51.6 percent of BHO members); 14.6 percent said their service coordinator “usually” involved them in decisions about services (14.4 percent of MCO and 16.1 percent of BHO members).
- 39.9 percent were “very satisfied” with the help they received from their service coordinator (41.1 percent of MCO and 32.3 percent of BHO members).

4.3.9. Summary and Recommendations for STAR+PLUS Adults

- Three-quarters or more of STAR+PLUS adult members:
  - Received counseling or treatment for mental health disorders.
  - Obtained information from their clinician about managing their mental health condition.
  - Took prescription medications as part of their mental health treatment.
  - Felt they could refuse medication or treatment for their mental health condition.
  - Provided high ratings of patient privacy and cultural competence.

The EQRO recommends that STAR+PLUS MCOs continue to encourage STAR+PLUS members to be active participants in their own behavioral health care, as patient engagement is related to better health outcomes.[53] Also, MCOs should identify those members who did not receive counseling or treatment and information on how to manage their mental health disorders, and conduct focus studies with members to identify common obstacles (e.g., related to their health, MCO, provider, personal barriers) they encounter in achieving better behavioral health care and outcomes. Additionally, studies using geographic information system (GIS) analyses can help determine physical barriers (e.g., distance to care, transportation).

- Half of STAR+PLUS adult members were obese.
- Few members rated their overall health, mental health, and recovery as “excellent” (4.1 percent to 15.3 percent).
- Half of members thought that counseling or treatment helped them “a lot” and were “very helpful” for their quality of life.
- One-quarter of members said they were “much better” across multiple domains than one year ago.

Focus should be given to tailoring health interventions to the complex needs of STAR+PLUS adult members with behavioral health disorders (e.g., weight management, substance use disorders, relapse prevention, psychiatric symptoms).[54] For example, similar to STAR adult members, comprehensive health interventions should address issues surrounding weight management and the relationship with behavioral health medications and compliance. Additionally, focus studies with STAR+PLUS members are needed to assess why counseling or treatment may not have worked well for some members and identify other types of behavioral health care which may be more appropriate or preferred.

- One-quarter of members had used up their benefits for counseling or treatment; of those:
  - Three-quarters thought they still needed counseling or treatment.
    - One-half of members who thought they still needed counseling or treatment were told of other treatment options.
- Four in ten members received counseling and treatment in the emergency department or crisis center.
- Only one-half of members were aware of available service coordination; among those who were aware:
  - One-half had a service coordinator.
    - One-half of members who needed service coordination in the past six months reported positive experiences.

It is possible that members do not understand the MCO's behavioral benefits package or may disagree with their providers or MCOs regarding which extended benefits are "medically necessary." If a clinician requests prior authorization for additional counseling or treatment visits and the MCO denies the request based on lack of medical necessity, the member may still believe that they are in need of additional treatment. Qualitative studies would provide a better understanding of STAR+PLUS members' behavioral health care needs and experiences and also allow for an assessment of their reasons for seeking behavioral health treatment in the emergency department (e.g., benefits are used up, acute mental health condition). Understanding their experiences and behavioral health care utilization will help better tailor programs to their needs. STAR+PLUS members have specific service coordination available to them because of their complex and costly medical needs, but few members are aware of it. Members' awareness of service coordination availability, which provides a range of services to address their complex needs,[55] should be addressed. Additionally, assurances need to be made that health intervention programs are reaching STAR+PLUS members. Results from a prior administrative interview survey showed that the vast majority of MCOs included educational materials and referrals to community resources. However, MCOs noted concerns about a large number of incorrect member addresses and returned mailings.[56] Studies are needed that examine the extent of this issue to ensure greater outreach and better care provision to STAR+PLUS members.

The EQRO overall found no significant differences, with only one exception, in STAR+PLUS adult member ratings between those who received behavioral health care through an MCO compared to a BHO, suggesting that their experiences and satisfaction with behavioral health care and outcomes are generally similar regardless of the delivery model.

4.3.10. STAR+PLUS Dually Eligible Members

Because STAR+PLUS adult members can receive either only Medicaid (N = 1,483) or Medicaid and Medicare (N = 233), the EQRO conducted additional analyses to assess significant differences in member reports between STAR+PLUS adult members receiving only Medicaid and STAR+PLUS adult members who are dually eligible. It is important to remember that dually eligible members receive most outpatient behavioral health care from Medicare and intensive rehabilitation and substance use disorder services from Medicaid. There were no significant differences in their responses for any of the variables examined for the STAR+PLUS adult Medicaid-only members above, with two exceptions. For the ECHO® composites *How Well Clinicians Communicate* and *Information about Treatment Options*, members who were dually eligible scored lower than Medicaid-only members (**Table 8)**.

Table 8. ECHO® Composites for STAR+PLUS Adult Medicaid-Only Members and STAR+PLUS Adult Dually Eligible Members

ECHO® Composite	Medicaid-Only Mean (SE); [Upper CL, Lower CL][2]	Dually Eligible Mean (SE) [Upper CL, Lower CL]
Getting Treatment Quickly	2.1 (0.0) [2.0, 2.1]	2.0 (0.1) [1.8, 2.2]
How Well Clinicians Communicate	**2.4 (0.0) [2.3, 2.4]**	**2.2 (0.0) [2.1, 2.3]**
Perceived Improvement	2.6 (0.0) [2.6, 2.7]	2.6 (0.1) [2.4, 2.7]
Information About Treatment Options	**0.5 (0.0) [0.4, 0.5]**	**0.4 (0.0) [0.3, 0.4]**

Because of sample size restrictions, comparisons could not be made for one variable: Among members who were aware of service coordination and received help from service coordinators, the EQRO could not determine if there were significant differences in getting help as soon as needed. Additionally, comparisons were not possible by delivery plan (MCO or BHO) for members who were dually eligible because these members received behavioral health care through an MCO.

[2] Bold indicates a statistically significant difference between members who were receiving only Medicaid and members who were dually eligible.

Endnotes

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[28] Although NorthSTAR contracts with the ValueOptions BHO, for the purpose of this study NorthSTAR is considered a separate delivery model from the standard MCO and BHO models. Members receiving behavioral health services through NorthSTAR must navigate three levels of administration – their primary Medicaid managed care program (STAR or STAR+PLUS), NorthSTAR, and the BHO.

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